Shiloh Dental Group

301 Tamarack Lane Shiloh, IL
62269 618.632.5566

PATIENT REGISTRATION

Date_____

Patient Information: (CONFIDENTIAL)

Name_____MI_____ Birthdate_____ SS#_____
Address_____City_____State_____Zip_____
Email_____ Home Ph_____ Cell Ph_____
Check Appropriate Box: □ Minor □ Single □ Married □Divorced □Widowed □ Separated
Person to contact in case of emergency?_____Relationship_____ Phone _____

Responsible Party:

Person responsible for account_____Relationship_____
Address_____City_____State_____Zip_____
Email_____Cell Ph_____Home Ph_____
Birthdate_____ Work Phone_____ SS#_____
Is this person currently a patient in our office? □ Yes □ No

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have another insurance coverage, complete this for 2nd coverage**
Insured's name	**Insured's name**
Insured's employer	**Insured's employer**
Insurance Co	**Insurance Co**
Insurance Co Address	**Insurance Co Address**
Phone # **DOB**	**Phone #** **DOB**
SS#	**SS#**
Group # **Local #**	**Group #** **Local #**

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. ☐

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 40%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is a s accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Parent if child)_____ **Date**_____

Patient's Name: _____

DENTAL/MEDICAL HISTORY

Are you under a physician's care? What for?_____ Family Physician _____ Phone Number _____
_____

What medications are you currently taking?_____ Women: Are you pregnant? Y N
_____ Are you nursing? Y N Oral Contraceptives? Y N

Are you on a special diet? Y N Do you use tobacco? How much per day/week? _____ Do you use controlled substances? Y N

Do you drink alcohol? How much per day/week? _____ Have you ever taken Phen-Fen or Redux? Y N Have you had a serious neck injury? Y N

Do you have difficulty opening your mouth? Y N Do you clench or grind your teeth? Y N

Have you had difficulty with dental extractions, prolonged bleeding post-operatively in the past? Y N

Have you ever been advised by a physician to take a pre-medication before any dental appointments? Y N

Would you like to discuss cosmetic smile enhancement? Y N

Please circle items below if you have or have had any of the following:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B OR C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy/Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives/Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pace Maker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

Other: _____

Are you allergic or have you reacted adversely to any of the following medications:

Aspirin	Codeine	Sedatives	Local Anesthetics
Iodine	Penicillin	Sulfa Drugs	Erythromycin
Tetracycline	Any Metals (Nickel, Mercury)	Barbiturates	Latex Rubber

Other: _____

Have you ever taken any of the following medications or any other Bisphosponates?:

Actonel	Aredia	Boniva	Fosamax
Zometa	Reclast	Herbal Suppletments	

Consent:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____
Patient Signature **Date** **Dentist Signature**

NOTICE OF PRIVACY PRACTICES

Shiloh Dental Group
301 Tamarack Lane – Shiloh, IL 62269
Phone: 618.632.5566

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your voice mail or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office at the address, fax, or email shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address, fax or email shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within thirty days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can

have one thirty day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office at the address, fax or email shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within sixty days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one thirty day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office at the address, fax or email shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within sixty days of receiving it, but by law we can have one thirty day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address, fax or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.

{Shiloh Dental Group}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
{Please Print Name} Relationship

_____ _____
{Please Print Name} Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____