Today's Date: _____

PATIENT INFORMATION

First Name:_____Last Name:_____ Middle Initial:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone (____)_____-_____ Social Security #: _____

Cell Phone:(____)_____-_____ Birth Date: _____

E-Mail Address: _____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed Occupation:_____

Name of Employer: _____ Phone: _____

City: _____ State: _____ Zip: _____

Physician's Name: _____ Phone: _____

Main Dental Concern: _____

Do you use a pre-medication prior to dental treatment (Antibiotic)? □ Yes □ No

- If yes, what is the name of your pre-med? _____

Has any member of your family ever been treated in our office: □ Yes □ No

Who may we thank for referring you to our office? _____

** We reserve time for you. If you are going to be unable to make your appointment, please notify the office 48 hours in advance if at all possible. **Failure to notify the office may result in a charge. ****

Please specify the best contact person/number to confirm all family member appointments:

_____

EMERGENCY CONTACT:

Name: _____ Phone: _____

RESPONSIBLE PARTY: (If not self)

□Self □ Spouse □ Father □ Mother □ Guardian

Name: _____Birthdate: _____ Social Security #:_____

Address: _____City:_____ State: _____ Zip:_____

Home Phone: ( )_____-_____ Cell: ( )_____-_____

PLEASE TURN OVER TO COMPLETE FORM

MEDICAL HISTORY

*** PLEASE MARK ANY CONDITION WHICH YOU HAD OR HAVE AT PRESENT TIME***

CONDITIONS

□ Abnormal Bleeding
□ Alcohol Abuse
□ Allergies
□ Anemia
□ Angina Pectoris
□ Arthritis
□ Artificial Heart Valve
□ Asthma
□ Blood Transfusion
□ Cancer
If yes,
what _____
when_____
□ Chemotherapy/ Bisphosphonates
□ Colitis
□ Congenital Heart Defect
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Facial Surgery
□ Fainting Spells
□ Fever Blisters
□ Frequent Headaches
□ Glaucoma
□ HIV + Aids
□ Heart Attack
□ Heart Murmur
□ Heart Surgery
□ Hemophilia
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ High Blood Pressure
□ Joint Replacement
If yes,
what _____
when_____
□ Kidney Problems
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Pace Maker
□ Psychiatric Problems
□ Radiation Therapy
□ Rheumatic Fever
□ Seizures
□ Sexually Transmitted Disease
□ Shingles
□ Sickle Cell Disease
□ Sinus Problems
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcers

ALLERGIES

□ Aspirin
□ Penicillin
□ Codeine
□ Dental Anesthetics
□ Erythomycin
□ Latex
□ Metals
□ Sulfa
□ Tetracycline
□ Other _____
_____

Y	**N**	
□	□	Do you smoke or use tobacco?

If Female:

Are you taking birth control pills?
YES □ **NO** □

Are you pregnant?
YES □ **NO** □
If yes, # of weeks_____

Are you nursing?
YES□ **NO**□

MEDICATIONS

Please list any medications you are currently taking:

_____

_____

TREATMENT AUTHORIZATION FORM

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding any medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____
Patient's Signature Date

If patient is a child or requires a guardian:

_____ _____
Parent/Guardian Signature Date

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents, or children to call our office and speak to someone regarding their medical conditions and medications, dental treatment and financial information. Under the requirement for H.I.P.A.A we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental, medical, and financial information released to any family members you must sign this form.

You have to right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Bircher Family Dental Care to release my records and any information to the following individuals:

1. _____Relation to Patient:_____
Phone Number:_____

2._____ Relation to Patient:_____
Phone Number:_____

3._____Relation to Patient:_____
Phone Number:_____

4._____Relation to Patient:_____
Phone Number:_____

5._____Relation to Patient:_____
Phone Number:_____

_____ _____
Patient Name (PLEASE PRINT) DATE

_____
PATIENT SIGNATURE

BIRCHER FAMILY DENTAL CARE

FINANCIAL POLICY

Thank you for selecting us as your personal dental care team. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. Please read this carefully and ask any questions or bring up any concerns you may have before treatment is rendered. Submission to treatment implies you consent to terms of this agreement.

TREATMENT: You will find our entire office staff is dedicated to helping you improve your dental health as efficiently as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE: Even if our office is able to accept direct insurance assignment, the patient or responsible party is still fully responsible for the charges for the treatment rendered. Your insurance may not cover the services or may only partially cover them and any estimate given by this office is considered a guideline until insurance payment is received and the patient's account is reconciled. The office can make no guarantee of the actual payment by your insurance company.

MISSED APPOINTMENTS: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep the appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 48 hours notice when you realize that you cannot keep your appointment. When the requested notice is not given, a missed appointment fee may be charged. For those whose schedules make it difficult to effectively plan ahead, we ask that you do not schedule an appointment in advance, but rather call us the day you can come in and we will be happy to see you then-provided the time is available.

PAYMENT IS DUE AT THE TIME OF SERVICE: We accept cash, personal checks, Mastercard, Visa and Discover. In addition, we offer outside financing with CareCredit for those requiring extended payment plans. When insurance applies we will collect any deductible and estimated co-payment at the time of service. We have payment options available for patients needing extensive dental work. Payment arrangements must be approved before services are rendered. Please see the receptionist for more information.

SERVICE CHARGES:

1. **RETURNED CHECKS** will result in a $25 fee charged to your account. Replacement of funds must be paid by cash or credit card.
2. **COLLECTION FEES** incurred to collect unpaid balances as a result of failure to conform to the terms of this agreement are the responsibility of the patient or responsible party.

Signature: _____ Date:_____
(Patient/Parent or Legal Guardian if patient is a minor)

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE (Please provide insurance card)

Name of Insurance Company: _____

Name of Policyholder: _____ Policy Holder Birth Date: _____

Relationship to patient: □ Self □ Spouse □ Child □ Other

Policy Holder SSN or ID#: _____

Address (if different than patients): _____

City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____ City/State/Zip: _____

SECONDARY DENTAL INSURANCE

Name of Insurance Company: _____

Name of Policyholder: _____ Policy Holder Birth Date: _____

Relationship to patient: □ Self □ Spouse □ Child □ Other

Policy Holder SSN or ID#: _____

Address (if different than patients): _____

City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____ City/State/Zip: _____

- We accept most dental insurances. Please provide your dental card to the receptionist to verify your dental coverage. We can then provide you with an estimate of your dental services to be rendered. Any deductible or copay will be due at the time of service. Once our office receives payment from your insurance company, we will send you a bill for any remaining balance not covered by your insurance.
- If you have no dental insurance, full payment for the dental treatment provided is due at the time of service. For your convenience, we accept cash, personal checks, and VISA, MasterCard and Discover cards. For our patients who need extended payment plans, we offer CARE CREDIT, as a financing option. Please ask the front desk for more information.

INSURANCE AUTHORIZATION STATEMENT (Please sign and date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

SIGNATURE _____ **DATE** _____

Notice of Privacy

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information, about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers, and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as employee medical reimbursement accounts.

Operations: We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages and letter), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations or payment), and in some cases to law enforcement and court ordered releases.

YOUR RIGHTS

Restrictions: You have the right to restrict to request restrictions or disclosure usage. We are not required to accept these restrictions but we will make a note of the request and honor that request if applicable. Access; You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Illinois State Board of Dental Examiners.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you submit a written complaint U.S-Department of Health and Human Services. We can provide you with the address upon request.

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:_____

_____

_____

Staff Name:_____

Signature:_____

Date:_____