7600 W. College Drive
Suite 10
Palos Heights, Illinois 60463

PURE DENTISTRY

PATRICIA GENNARO, D.D.S.

Phone: 708.448.5675
Fax: 708.448.5514
Email: info@palosdentistry.com

TODAY'S DATE: _____

PATIENT: (Mr., Mrs., Ms.) _____ ____ _____
FIRST MI LAST

Nickname/preferred first name: _____

Date of Birth _____ Soc. Sec. No. _____

Home Address _____

_____ _____ _____
CITY STATE ZIP CODE

Home Phone(____)_____ Cell Phone: _____

Marital Status _____ If Student [ ] Full Time [ ] Part Time [ ] School _____

E-MAIL: _____ Preferred method of contact: [ ] no preference [ ] e-mail [ ] text [ ] phone call

EMERGENCY CONTACT:

_____
FIRST AND LAST NAME MOBILE TELEPHONE NUMBER

Who has referred you to our office? _____
FIRST NAME LAST NAME

What is the reason for your visit today? _____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR YOUR ACCOUNT (GUARANTOR):

[ ] SELF [ ] SPOUSE [ ] MOTHER [ ] FATHER [ ] OTHER

Name: _____ _____ Relationship to Patient:_____
FIRST NAME **(IF DIFFERENT FROM ABOVE)** LAST NAME

INSURED PARTY

Name: _____ _____
(IF DIFFERENT FROM ABOVE)

Address: _____
CITY STATE ZIP CODE

Home Phone: (___)_____ Cell Phone: (___)_____

Date of Birth: _____ SSN: _____

Name of Dental Insurance Company: _____
CITY STATE ZIP

Employer: _____ Occupation: _____

Policy ID# _____ Group #_____

MEDICAL HISTORY

ALL HEALTH HISTORY QUESTIONS ARE REQUIRED AND NEED TO BE FILLED OUT COMPLETELY.

Have you ever had any of the following? ONLY CHECK THOSE THAT APPLY:

- ☐ Atrial- FIB
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ JOINT Replacement
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Chemotherapy Treatment? Date:_____
- ☐ Radiation Treatment? Date:_____
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Thyroid Problems
- ☐ Fen-Phen/Redux
- ☐ Osteoporosis
- ☐ Currently Pregnant
- ☐ Penicillin Allergy
- ☐ LATEX Allergy
- ☐ SULFA Allergy
- ☐ NOVOCAINE Allergy
- ☐ Codeine Allergy
- ☐ OTHER: PLEASE LIST

_____

_____

_____

- ☐ ***NONE OF THE ABOVE!**
- ☐ **Currently use a Night Guard**
- ☐ **Currently use a Sleep Appliance**

1.) Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

2.) Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

3.) Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

4.) Name of Physician: _____ Phone: _____

5.) Has a physician - M.D. ever told you to take antibiotics prior to dental treatment? ☐ Yes ☐ No

6.) Do you, or have you ever taken Fosomax, Boniva, Reclast, Zometa or other osteoporosis drugs? ☐ Yes ☐ No
If so, WHEN?_____ HOW LONG?_____

7.) Do you have jaw joint (TMJ) trouble? Clicking, popping, pain, limitation of opening? ☐ Yes ☐ No

8.) Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

9.) • Please list the names of ALL medications currently taking:

_____

Financial Policy and Consent for Services

Please Read Carefully

If you have dental insurance, our office will work with you to maximize your allowable insurance benefits. It is understood that the dental treatment will be diagnosed based on your dental health and not your insurance coverage. It is further understood that since your insurance is a contract between you and your insurance company/employer, our practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment for all treatment received from the practice regardless of your insurance status.

***Payment, including insurance deductibles and co-pays for all treatment is due at the time services are rendered** unless other payment arrangements have been made in advance. Co-pays are estimates based on the information provided by your insurance company.

If you fail to show for a scheduled appointment or cancel an appointment within less than 24 hours advance notice, a broken appointment fee of $100 may be assessed to your account.

Returned checks and declined credit cards due to insufficient funds or otherwise will result in an additional fee added to the amount due on your account.

Payments for services may be made by cash, check, Care Credit, and all major credit cards including: Visa, Mastercard, Discover, Amex. These were arranged to reduce the financial barriers for our patients in receiving optimal dental care treatment.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding **60** days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

To the best of my knowledge, all of the preceding answers above and all information provided on this form are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I have read the above consent of services and payment and agree to their content.

***PRINT YOUR NAME*_____Date: _____**

*** SIGNATURE**

***_____**

[of patient, parent, or guardian] MUST BE SIGNED.

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Insurance Information Disclaimer

It is very important to us for any dental patient to have some understanding of how dental insurance works. Your employer contracts with an insurance company, then the insurance company creates a custom tailored policy based on what your company is willing to pay as a premium. This policy is unique to your company although it may share some similarities to other policies. The insurance company has the ability, based on the legal document "policy", to pay or not pay any claim at any time or to exclude certain procedures etc to limit their exposure. Their legal relationship is with you, the patient, and *not the dental office, which is a third party provider.*

The information is very limited as to what they tell us. The insurance company stresses to us that the information received "does not guarantee reimbursement." We do not receive information on specifics of your individual policy.

Please understand as a patient at Pure Dentistry, we do everything possible to ensure that you get your maximum benefit from the insurance. We also believe that insurance companies should not dictate treatment for a patient. It is important that you understand that when you receive a treatment plan from our office that it is an ESTIMATE ONLY and not a guarantee. We cannot possibly know all the ins and outs of your insurance policy.

This document is our attempt to avoid any financial misunderstandings. We would like you to understand you are responsible for anything your insurance company does not cover and/or pay for any reason. Our goal as an office is to give you the best treatment possible and meet or exceed your expectations.

By signing this document, I have read and understand the above information.

Signature: _____ Date: _____

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PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with respect to protected health. This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any
use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above.

PRINT YOUR NAME:_____ Date:_____

SIGNATURE: _____
Signature of patient, parent, or guardian. MUST BE SIGNED

For more information about HIPPA:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201 Toll Free: 202-619-025