Fountains Family DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender:_____ Child ___ Single____ Married____ Other____ Social Security #: _____BirthDate_____

Phones: Home: _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

City : _____ State: _____ Zip Code: _____

Email:_____ Copy of photo id / Driver's License number _____

HEALTH INFORMATION

Yes No
- ☐ ☐ AIDS/HIV
- ☐ ☐ Allergies:

List: _____
- ☐ ☐ Heart Disease
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Attack
- ☐ ☐ Head Injuries
- ☐ ☐ Artificial Joints

Joint replaced and Date:_____
- ☐ ☐ Require pre-medication
- ☐ ☐ Kidney Disease
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Radiation Treatment
- ☐ ☐ Surgically Placed Implants

Date:_____
- ☐ ☐ Surgically Placed Pin or Rods

Date:_____

Yes No
- ☐ ☐ Anemia
- ☐ ☐ Glaucoma
- ☐ ☐ Arthritis
- ☐ ☐ Hay Fever
- ☐ ☐ Head Injuries
- ☐ ☐ Thyroid Disorders
- ☐ ☐ Stomach Problems
- ☐ ☐ High Blood Pressure
- ☐ ☐ Jaundice
- ☐ ☐ Blood Disease
- ☐ ☐ Mental Disorders
- ☐ ☐ Nervous Disorders
- ☐ ☐ Epilepsy
- ☐ ☐ Excessive Bleeding
- ☐ ☐ Hepatitis: (circle) A B C
- ☐ ☐ Asthma
- ☐ ☐ Organ Transplant

Date:_____

Yes No
- ☐ ☐ Pacemaker
- ☐ ☐ Osteoporosis
- ☐ ☐ Stroke
- ☐ ☐ Tumors
- ☐ ☐ Ulcers
- ☐ ☐ Venereal Disease
- ☐ ☐ Codeine Allergy
- ☐ ☐ Penicillin Allergy
- ☐ ☐ Tuberculosis
- ☐ ☐ Bio phosphonate
- ☐ ☐ Rheumatism
- ☐ ☐ Sinus Problems
- ☐ ☐ Sleep Apnea
- ☐ ☐ Respiratory Issues
- ☐ ☐ Diabetes
- ☐ ☐ Currently Pregnant

Due Date:_____

Please list any medications or herbal supplements you are taking currently:

_____

_____

Dental History

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you been having any specific dental problems?_____

Have you ever had any of the following? Please check all that apply:

Do your gums every bleed? Y / N Have you been told you have gum disease? Y/ N

Are you teeth straight? Y/N Do you have gaps between your teeth? Y / N Would you like to have straight teeth? Y / N

Do you like the color of your teeth? Y / N Would you like information about teeth whitening? Y / N

Do you have Sleep Apnea? Y / N Do you have a CPAP/BIPAP? Y / N

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? Y / N
  Name of Physician:_____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____ _____ Date:_____
Signature of patient or guardian Signature of Doctor

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS).

Each item is rated from 0 to 3: with 0 meaning you would never *doze or fall asleep* in a given situation; and 3 meaning that there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

Total Score _____

Name: _____

Date: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary Insurance Company Name _____

Insurance Company Phone Number _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Company Name _____

Insurance Company Phone Number _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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 of six months 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, or within five (5) days of billing if credit shall be extended. 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.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Payment is expected prior to time of service for estimated patient portion, unless other financing options have been made.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

.

Fountains Family DENTISTRY

TY PARKER DMD
314-C FOUNTAINS PARKWAY
FAIRVIEW HEIGHTS, IL 62208
618-622-1800

FINANCIAL POLICY

Our mission is to deliver the best most comprehensive dental care, and financial considerations should not be an obstacle to fulfilling your needs. Therefore, we provide a range of payment options for our patients.
We accept check, cash, debit cards, Visa, MasterCard, Discover, and American Express.

Insurance plans

We accept most dental plans and we will work to maximize your dental benefits and submit your insurance claims at no charge. For your convenience, we accept the insurance benefits directly from your insurance company, and only the estimated portion not covered by your insurance is due at the time of treatment prior to your dental appointment. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion.

Assignment and release: You, the undersigned assign directly to Fountains Family Dentistry all benefits, if any, otherwise payable to you for services rendered. You hereby authorize the doctor to release all information necessary to secure the payment of benefits. You authorize the use of your signature on all your insurance submissions whether manual or electronic.

Financing Options

We have partnered with Chase Health Advance and Care Credit, offering no interest and extended payment plans, making it easy and affordable to get the smile you've always wanted.
Flexible Spending Accounts- FSA and HSA's
If you work for a company that provides a flexible spending account or a health saving account, we can help you save up to 30% on your treatment cost by paying with non-taxable income.

PLEASE NOTE:
We require payment or a financial arrangement before the start of your treatment. If you choose to discontinue care before your treatment is complete, your refund will be determined upon review of your case. If after exhausting all efforts to collect the unpaid account balance through our regular services from the patient/parent/guardian of signature, the unpaid balance along with a collection fee will be turned over to our collection agency Credit Control, LLC.
I have read the Financial Policy is its entirety. I understand and agree to its terms.

Patient, Parent or Guardian Signature _____ Date :_____

Cancelation Policy

Fountains Family Dentistry provides courtesy appointment reminders in numerous forms, giving everyone ample opportunity to notify us if for some reason you need to change or cancel a scheduled appointment. As we reserve time for you on our schedule, it is of upmost importance that you notify our office at least 48 business hours in advance by telephone if for any reason you need to cancel or change your scheduled appointment. We understand that sometimes there are unforeseen changes in everyone's schedule and our staff will do their very best to accommodate and reschedule your appointment. A $50.00 "Missed Appointment Fee" may be charged to your account if you fail to show up and/or provide our office the appropriate notification. Thank you for your understanding on this matter.

I have read the Cancelation Policy is its entirety. I understand and agree to its terms.

Patient, Parent or Guardian Signature _____ Date :_____

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HIPAA Notice of Privacy Practice

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

This Notice of Privacy Practices describes how we my use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, and future physical health condition and related health care services.

Uses and disclosure of protected health information: **Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians' practice and any other use required by law.**

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers compensation, inmates, and other required uses and disclosures. Under the law we, must make disclosures to you upon your request. We must also disclose your protected health information when required by the Secretary of the Department and Human Services to investigate or determine our compliance with the requirements under Section 164.500

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following are statements of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information (fees may apply).You have the right to request a restriction of your protected health information. You have the right to receive and accounting of certain disclosures. You have the right to obtain a paper copy of this notice from us at any time.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file file a complaint with us by notifying our Compliance Officer, Christine Lung. We will not retaliate against you.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Please sign the accompanying "acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

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Acknowledgement of our Notice of Privacy Practice

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Fountains Family Dentistry Notice of Privacy Practices, for all who are in my household or under my insurance. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Print) **Date**

_____

Signature