PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

Date of last exam: _____

Date of last x-rays: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Jill Kinsella, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person Kathy Jones
Telephone: (618) 744-1969
Address: 735 Seibert Rd., Suite 2, Scott AFB, IL 62225

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

General Office and Financial Policy

General Policy Provision

We are committed to providing our patients with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our policy regarding payment for services and dental insurance. Please review the following guidelines and initial accordingly that you acknowledge and understand the statement.

_____Payment in full is due at the time services are rendered unless prior arrangements are made. We gladly accept cash, checks, debit cards and the following credit cards: Visa, MasterCard, Discover, and Care Credit. If there is insurance on file we will collect your ESTIMATED portion only at the time of service. If you do not have your co-pay you will be asked to reschedule your appointment or set up a payment plan.

_____The parent or guardian who brings a child for his/her visit is responsible for payment regardless of what individual circumstances may be or what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

_____Fees for treatment are guaranteed for six months from the date of the check up when the treatment plan is presented (not the date when the treatment plan is signed). After such 6 month period, fees may be subject to change.

_____Patients are responsible for keeping their scheduled appointments. We require at least 48 hours prior notice if an appointment cannot be kept, since the time has been reserved for you. Please help us serve you better by keeping scheduled appointments. This policy is set in place so that we, at Jill Kinsella, DMD, may provide all our patients with appointments as needed. A broken appointment fee will be incurred if less than 48 hour notice is given. Multiple broken appointments will result in dismissal as a patient from Jill Kinsella, DMD.

_____There will be a $30.00 service charge on all returned checks and I will be required to pay cash or use a credit card for any future payments for a period of one year. Failure to repay the returned check and the returned check fee will result in collection proceedings and dismissal as a patient from Jill Kinsella, DMD.

_____You will be responsible for payment of all costs and fees incurred, including attorneys' fees, should collection efforts be made in order to fulfill a debt.

_____Parents and/or guardians are required to accompany and remain in the office with their child/children during all visits to our office. If someone other than the parent or guardian will accompany the child/patient on a visit, written authorization from the parent or guardian must be provided to us prior to any treatment being performed on the child/patient.

Continued on page 2

General Office and Financial Policy

(Continued)

_____I understand that Jill Kinsella, DMD has the right to discharge any patient from this practice at any time for various reasons, including, but not limited to failure to abide by Jill Kinsella, DMD financial policies, noncompliance of recommended treatment, drug-seeking activity, and any abuse of Jill Kinsella, DMD providers and staff.

_____If this occurs, I understand that my dental records will be released to a dentist of my choice only after appropriately signed documentation is received by Jill Kinsella, DMD. I further understand that once discharged from Jill Kinsella, DMD, I will not be allowed to return as a patient in the future.

INSURANCE POLICY PROVISION

_____Your insurance policy is a contract between you, your employer and the insurance company. The amount of coverage you will receive will depend on the quality of the plan purchased by yourself or your employer. All charges you incur are your responsibility regardless of your insurance coverage.

_____Please be aware that some, or perhaps, all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company. We are not responsible for any limitations in coverage that may be included in your plan. You are responsible for knowing the details of your specific dental plan.

_____ _____

Individual/Parent/Guardian/Responsible Party Signature Date

Dental Services Financial Agreement

Our goal is to help you establish excellent oral health. Our team is committed to helping you determine the most appropriate treatment for your dental needs and desires. Should you have questions concerning your treatment, treatment sequence, or fees for services, please ask for clarification before treatment is begun.

Our financial policy is as follows:

- We accept cash, personal checks, and most major credit cards including **MasterCard, Visa and Discover**
- Payment is due at the time of service.
- Payment plans for certain procedures are available through Care Credit with payment options available up to **24 months** at fixed rates.
- Insurance -- is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. We will be happy to assist you by filing your insurance claim and answering the details that the insurance company may require. We cannot be responsible for payment by the insurance company. **The responsibility for payment belongs to the patient.**
- We will provide estimated balances between the cost of service and co-payment of your insurance. Predetermination of benefits may be advisable if there is a question concerning coverage.
- We will accept assignment of benefits subject to verification of insurance coverage.
- Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment is begun.

We reserve the right to accept or deny certain insurance plans at our discretion. If we accept your insurance plan, your estimated co-payment is due at the time of service. If your insurance company has not paid the ***full balance*** within 60 days, you will have 30 days to pay the balance. A monthly finance charge of **1.5**% will be added to any unpaid balances after 90 days from date of service.

Should your insurance plan be denied, full payment is expected at the time of service unless prior arrangements have been made through our office manager. A monthly finance charge of **1.5** percent will be added to any unpaid balances after 90 days from date of service.

Please remember that you are responsible for timely payment of your account. Should it become necessary to refer your account to an agency or attorney for collection, you will also be responsible for all costs associated with the collection including attorney's fees and court costs.

I understand the above policy and agree to the terms herein.

_____

Individual/Parent/Guardian/Responsible Party Date