Bucktown Wicker Park Dental

Patient Registration

First Name: _____ Middle Initial: _____ Last Name:_____
Preferred Name: _____
Address: _____ Home Phone:(____)_____-_____
City: _____ State: _____ Zip: _____ Cell Phone: (____)_____-____
Email Address: _____ Preferred contact method: Call/ Text/ Email
Birth Date: _____/_____/_____ Age: _____ Sex: Male/Female
Marital Status: Married/ Single/ Widow Occupation: _____ SSN:_____
Emergency Contact: _____ Phone: (____)_____-_____
How did you hear about our office?_____
Is there anyone we can thank for referring you?_____

Dental Insurance Information

Subscriber: _____ Date of Birth: _____/_____/_____
Subscriber SSN: _____-_____-_____ Relationship to subscriber:_____
Employer: _____ Business Phone:(_____)_____-_____
Insurance Company: _____ Insurance Phone: (_____) _____-_____
Group Number: _____ Patient ID: _____

Responsible Party (if other than patient)

Name: _____ Date of Birth:_____/_____/_____
Address: _____ SSN:_____
_____ Relationship to Patient:_____
Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ CellPhone: (____)_____-_____

Regarding HIPAA

We will not discuss your protected health information unless authorized by you. If you would like to discuss your treatment or account with anyone else please provide the person(s) name relationship to you below.

Name: _____ Relationship: _____

We are required by federal and state law to maintain the privacy of your health information. We also required to give you information about our privacy practices. By signing below, you are acknowledging you have had a chance to review a copy of our HIPAA privacy handout.

**Signature: _____ Date: _____/_____/_____

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MEDICAL HISTORY

Name:_____ 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 to the best of your ability.

Primary Care Physician: _____ Phone: (_____) _____-_____

Y N Abnormal Bleeding	Y N Anemia	Y N Anxiety/Nervous Disorder
Y N Arthritis	Y N Asthma/Hay Fever	Y N Artificial Heart Valves
Y N Artificial Joints	Y N Cancer	Y N Chemical Dependency
Y N Congenital Heart Defect	Y N Coronavirus	Y N Dementia/Alzheimer's
Y N Diabetes	Y N Epilepsy/Seizures	Y N Fever Blisters/Cold Sores
Y N Frequent Headaches	Y N Frequent Urination at Night	Y N Gastrointestinal Disorders
Y N Heart Problems	Y N Heart Murmur	Y N Hemophilia
Y N Hepatitis/Liver Problems	Y N High Blood Pressure	Y N High Cholesterol
Y N Herpes	Y N HIV/Aids	Y N Insomnia
Y N Kidney Problems	Y N Mitral Valve Prolapse	Y N Pacemaker
Y N Psychiatric Problems	Y N Reflux	Y N Radiation/Chemotherapy
Y N Restless Leg Syndrome	Y N Sinus Problems	Y N Sleep Apnea
Y N Stroke	Y N Tuberculosis	Y N Ulcer/Colitis
Y N Trouble Sleeping	Y N Wake Up Frequently at Night	

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y N

Do you use/or have used tobacco products (including e-cigarettes) or marijuana? Y N How much per week ___

Do you consume alcohol? Y N How much per week? _____

Have you been told that you snore? Y N

Do you wear/ or have worn a C-PAP? Y N

Have you ever had a sleep study? Y N

Allergies:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Sulfa
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline
Other: _____

Females Only:

Y N Are you taking birth control pills?
Y N Are you nursing?
Y N Are you pregnant? # of weeks _____

Please list all medications that you are currently taking: _____

_____

_____

Any other medical conditions not listed. Please describe: _____

_____

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DENTAL HISTORY

Name:_____ Date:_____

What are you seeking dental care at this time? _____
Are you currently in dental discomfort? _____
You feel your dental health is: Good Fair Poor
Approximate date of your last checkup/cleaning? _____ Your last set of X-rays? _____
Former Dentist Name:_____ Phone: (_____)_____-_____
Why did you leave your previous dentist? _____
Have you been told by your physician that you require antibiotics before dental treatment? Y N

How do you feel about the appearance of your smile? _____
If you can change anything about your teeth, what would it be? _____
How often do you brush your teeth? _____ Type of Toothbrush: Manual Electric
How often do you floss your teeth? _____ Do you use mouthwash? Y N

Y N Is it important to you to keep your teeth?
Y N Does food frequently get caught between your teeth?
Y N Do your gums often bleed while brushing?
Y N Have you noticed any loosening of your teeth?
Y N Have you ever injured your teeth, head, neck or jaw?
Y N Do you have difficulty eating or swallowing?
Y N Do you have dry mouth?
Y N Do you notice if you are a mouth-breather?
Y N Have you had a change in your ability to taste food?
Y N Are your teeth sensitive to hot or cold?
Y N Are your teeth sensitive when you bite down?
Y N Do you experience bad breath?

Problems of the jaw - Have you noticed:
Y N Clicking of the jaw?
Y N Pain (joint, ear, side of face)?
Y N Difficulty opening or closing?
Y N Difficulty chewing?

Do you currently have:
Y N Dental Pain?
Y N Sores or swelling in your mouth?
Y N A partial/ full denture?
Y N Dental Implants?

Oral habits: Do you?
Y N Clench or grind your teeth?
Y N Bite your lips or cheeks frequently?
Y N Thumb or Tongue habit?
Have you had:
Y N Orthodontic treatment? (Braces)
Y N A bite guard/ night guard or other appliances?
Y N Oral Cancer?

Do you have any dental anxiety? Yes / No
Have you had any difficulty with dental treatment in the past? Yes / No
Please explain: _____
_____
_____

Bucktown Wicker Park Dental

FINANCIAL AND CANCELLATION POLICY

Bucktown Wicker Park Dental does not participate in Health Management Organization (HMO); however our office does participate in many insurance plans. A list of the plans we accept is available on our website: www.bucktowndental.com on the main page.

Please read and initial the following statements.

_____ Your portion for services rendered are due at the time of service. Patients with insurance are required to pay the deductible (if applicable) and estimated co-payment or portions at the time of service. We are more than happy to assist you with the filing of your insurance, however, keep in mind that the co-payment/patient portion amount is an ESTIMATE. You are responsible for any account balance that is not paid by your insurance company.

_____ In order to provide our patients a safe environment to receive the best dental care during this COVID-19 pandemic, a $10 COVID PPE Fee has been implemented for each dental visit per person. This fee covers extra upgraded sanitation precautions such as air purification system, additional upgraded PPE and sterilization protocol, increased infection control and a high evacuation system to minimize aerosol.

_____ Emergency New Patients will be required to pay for full service on the day of service. Our office will file the insurance claim and insurance payment will go directly to the patient.

_____ Our policy is that we require your insurance to pay out claims within 60 days. Most insurance companies pay within 45 days. I authorize payment of my dental benefits, otherwise payable to me, directly to Bucktown Wicker Park Dental. If the claim becomes outstanding after 60 days, you will be notified on your next statement and the full balance will be due. A credit card is required to be kept on file for any incidental charges not paid by your insurance company. Patients will receive an email confirmation 1 week prior to the credit card on file being run. Patients will receive an email receipt for any amount that is charged to their credit card. Patient is responsible to notify the office if the credit card on file is cancelled or changed.

_____ If your treatment requires two or more visits to our office (i.e. crowns, implants, veneers, bridges, partials or dentures), your balance for the estimated patient portions will be due on the first day of treatment unless payment arrangements have been made prior to the start of treatment. Any remaining balance will be processed through auto-debit and arranged through the credit card on file. A deposit will be needed to hold long appointments with the Doctor.

_____ In order to help our patients with no insurance benefits, our patients can take advantage of our In-Office Dental Savings Plan (The Smile Advantage Plan) or Care Credit, a third party lender.

_____ We value our patient's time. Your appointment is reserved for you. We know emergencies do occur. However, we ask for the same courtesy for our doctor's/hygienist's time. We request that in order to avoid any cancellation fee, that a 24 hour notice prior to the dental appointment time be made. Appointment cancellations made on the voicemail or email must be made within 48 hours to avoid any charges. A fee of $50 per hour of time with a Dental Hygienist or $75 per hour with the doctor. If continuous last minute cancellations are noticed, a deposit may be required to hold an appointment with the hygienist or the dentist.

_____ A late charge of $10.00 per billing cycle will be imposed on balances not paid in full within 30 days of your first statement. The fee for returned checks is $30.00. You are responsible for any unpaid balance to the office and any legal fees to collect such debt.

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Financial and Cancellation Policy Acknowledgement

I have read, understood and agreed to the financial and cancellation policy. I understand that I am fully responsible for the fees of service rendered, regardless of any insurance that I may have.

Patient's Signature _____ Date_____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

CREDIT CARD INFORMATION

Name of Patient: _____ _____ _____
LAST FIRST MI

Name of Cardholder: _____ _____ _____
LAST FIRST MI

Card Type: ____M/C ___Visa ___ Amex _____Discover Exp Date: _____ CVV#: _____

Credit Card Number: _____ Is this an HSA Card? Yes No

Billing Address: _____

I hereby acknowledge receipt of services, authorize Bucktown Wicker Park Dental to bill the credit card I have provided above to keep on file for such services, and agree to take all further actions to pay the charges in full and to perform the obligation set forth in agreement with my credit card issuer.

Authorized Signature: _____ Date: _____

HIPAA Information
NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguard to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a concise version. A more complete text is available in our office. This is available to patients upon request. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance the needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, et. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

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DENTAL PHOTOGRAPHY ACKNOWLEDGEMENT

I, _____(authorize/ do not authorize) Bucktown Wicker Park Dental to take photographs, and/or videos of my face, jaws, and teeth, before, during and after dental treatment.

I consent to allow the photographs to be used for the following:

- Dental records
- Dental education
- Marketing material, including websites and patient education
- Social Media
- “Before and After” Photos

I further understand that if the photographs and/or videos are used, my name and other identifying information will be kept confidential unless full face photographs are used. These photos are the exclusive property of Bucktown Wicker Park Dental.

_____ _____

Patient’s Name Date

_____

Patient’s Signature