TOTAL CARE DENTAL
Delivering caring, comfortable dentistry to our community.

8441 W Lawrence Ave, Chicago, IL 60656
Tel: 773-589-1400 Fax: 773-589-1408 e-mail: totalcaredentalchi@gmail.com

How did you hear about our office? _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security#: _____

Address: _____Apt/House#_____

City: _____State: _____Zip Code: _____

Cell Phone #: _____ Email: _____

Emergency Contact: (Name) _____ (Phone#) _____

Please circle: Single Married/Partner Separate/Divorced Widowed

Patient Registration

Responsible Party (if other than patient)

Relationship to patient: (please circle) - Self Spouse Child Other_____

First Name: _____ Last Name_____

Date of Birth: _____Social Security#: _____

Address: _____Apt/House#_____

City: _____State: _____Zip Code: _____

Cell Phone #: _____ Email: _____

Employer Name: _____

INSURANCE INFORMATION

Records Release

This must be signed if any insurance is to be filed by you or us.

I hereby authorize Total Care Dental, P.C. to release to my insurance company any information acquired in the course of my examination or treatment.

Signed _____ Date _____

Assignment of Benefits

This must be signed if we are filing to your insurance company for payment.

I authorize my insurance company to pay my medical benefits to Total Care Dental, P.C. for services rendered. I understand that I am responsible for any unpaid balance.

Signed _____ Date _____

Insurance Waiver

This must be signed by, or on behalf of, all patients

I understand that services provided to me may not be a covered benefit as defined by my insurance company. I agree to be personally responsible for payment for the services rendered. I also agree to pay any co-pays and/or deductibles as required by my insurance company.

Signed _____ Date _____

Primary Insurance Information

Employer: _____	Insurance Co.: _____
Subscriber's Name: _____	Insurance Tel #: _____
Subscriber's DOB: _____	Insurance Group #: _____
Subscriber's SSN:_____	Insurance ID #: _____

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	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

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 Acrylic Metal Latex Local Anesthetics

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	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No

Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____
_____
_____

Comments: _____
_____
_____
_____

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 _____

Financial policy and release

Thank you for choosing us for your dental needs. We are committed to providing you with the best possible dental care. The following statement of our Financial Policy is provided to avoid any misunderstanding or disagreement concerning payment for professional services.
Insurance is a contract between you and the insurance company. It is your responsibility to know the requirements and stipulations of your policy and if we are contracted providers for your plan. Some services may not be covered benefits under your insurance plan and, therefore, payable directly by you.

Your insurance card must be brought and shown at each office visit. In order for us to verify identity, we will need a copy of your Driver's License or other state-issued picture identification.
If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to the Member Services department at your insurance company. The phone number can be found on the back of your insurance card.

Co-pays are due at the time of service. If you do not have insurance coverage, full payment is due at the time of service. We accept cash, Visa, MasterCard, Discover, American Express, and Care Credit.

Contracted PPO/POS/HMO and other Managed Care In-Network Plans
Prior to your visit, you should confirm with your insurance company that our dentists are participating (in network) providers for your plan.
It is the Guarantor's responsibility to understand the insurance benefits and pre-authorization requirements.

Non-Contracted PPO/POS/HMO and other Managed Care Out-of-Network Plans
If we are not contracted providers for your insurance plan, payment is due at the time of service. We will be happy to file a claim to your insurance company on your behalf so that you may receive appropriate reimbursement. For out-of-network claims, we do not follow insurance company fee schedules.
non-covered services.
Payment and Insurance
Not all insurance plans pay the same benefits or apply the same deductible amounts. There may be a balance due that you will be responsible for after your insurance company has paid us. If your insurance company does not respond within 30 days (as required by law), you will be liable for the charges. It is essential that the Guarantor provides us with the correct information for filing claims and to notify us of any changes in insurance or other information necessary for claims processing. Failure to notify us of proper information may result in insurance claim denial. In case of denial, you agree to be responsible for the charges.

We will bill your insurance company on your behalf and honor any contractual agreement that we have with your Insurance company, however, should the insurance company default on their agreement or not abide by the law, you are ultimately responsible for the charges. You agree to be personally responsible for non-covered services as determined by your insurance plan.

Past Due Accounts
We realize that temporary financial problems may affect timely payment of your account. After the Explanation of Benefits (EOB) has been received from your insurance company and posted to the account, any amount due from you and not paid by the 15th of the month following the billing date to the patient may be assessed a finance charge at an annual rate of 18% (1½% per month). Past due accounts of 90 days or more will be referred to a collection agency. An additional collection fee of 50% will be added to the balance to recover costs of collection.

Missed Appointment/Late Cancellations
Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. A $50.00 fee will be charged for missed appointments or cancellations less than 24 hours prior to the appointment. This fee is not reimbursable by your insurance company. Excessive abuse of missed appointments or late cancellations may result in discharge from the practice.

Other Services
Dental Records: A copy of your dental records is available upon request within 30 days (or less). By State statute, copying fees may be assessed.

Returned Checks: There will be a $25.00 service charge, for any returned checks.

Medication Requests: Telephone or fax requests for medications may incur a $25.00 fee under the following circumstances:

- When the patient hasn't been seen during the preceding three (3) months
- When the patient calls for medication with complaints of a new medical illness
- For non-emergency calls or requests after regular office hours

These fees are not submittable to, or reimbursable by, your insurance company.

Forms and Correspondence: It is not uncommon for patients to request the completion of disability forms, a personalized letter to refute a denied claim, a letter explaining the results of an exam to a third party, etc. These non-routine requests require additional time and resources. We will be happy to provide these services for a reasonable fee. We regret having to charge for these services, however, we thank you in advance for understanding that it is cost-prohibitive to fulfill these requests for free.
Our practice firmly believes that a good provider/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the office manager.

I have read and understand the Financial Policy described above. By choosing to proceed with care, I am also agreeing to abide by these policies.
Patient Name (please print) _____

Signature of Patient (or responsible party) _____Date:_____