Suburban
Oral Surgery
& Implant Center

Patient Information

First Name_____ M.I._____Last_____

Address _____ Sex M / F Age _____

City _____ Date of Birth _____

State _____ Zip Code_____ Social Security _____

Marital Status S M W D

Primary Phone _____ Physician _____

Alternate Phone _____ Dentist _____

E-mail _____ Referred By _____

Parent/ Legal Guardian (if patient is a minor) _____

Home Phone_____ Work/ Cell Phone _____

Emergency Contact _____ Tel. _____

Has a family member been a patient in our office? Yes No

Dental Insurance Information

Subscriber _____ Relationship to _____

Address _____ Home Phone _____

City _____ Cell Phone _____

State _____ Zip_____ Date of Birth _____

Employer _____ Social Security _____

Dental Insurance _____ Phone No. _____

ID No. _____ Group No. _____

Do you have Secondary Dental Insurance Coverage? ❑ Yes ❑ No
If so, please supply the front desk with your insurance card

Do you have Medical Insurance Coverage? ❑ Yes ❑ No
If so, please supply the front desk with your insurance card

Suburban
Oral Surgery
& Implant Center

Fees and Payments

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon the completion of each visit. Please speak to our office staff if other arrangements are necessary. An estimate of the charges for any procedure or surgery you may require will be given to you upon request.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a **substitute** for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **Any deposit made is an estimate of your co-insurance and may not reflect your final out-of-pocket expense. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

We will be happy to submit your claim on your behalf. However, if we do not receive payment from your insurance carrier within 60 days from the submission date you will be billed for your balance.

A $15.00 monthly late fee will be charged after your account is 30 days delinquent. If an account is turned over to our attorneys, you will be responsible for any attorney's fees and/or court costs.

A $100.00 cancellation fee will be charged for any missed or cancelled appointments that are not cancelled within 48 hours of the scheduled time.

A $20.00 NSF fee will be charged to your account for any returned checks.

The signature on file is my authorization for Suburban Oral Surgery and Implant Center to release information necessary to process my insurance claim, in consideration of those health care services rendered. I hereby assign and authorize direct payment to Suburban Oral Surgery and Implant Center of any insurance, health plan, or third party benefits otherwise payable to me.

I have had the opportunity to read and fully understand this consent for its content and significance. I agree with the information contained in this consent and confirm that I am the patient or am authorized to sign on the patient's behalf.

_____ _____

Name of Patient (Print) Date

_____

Signature of patient or guarantor/ guardian if patient is a minor.

Revised 1/10

Suburban
Oral Surgery
& Implant Center

HEALTH QUESTIONNAIRE

Name_____ Date _____

Primary Care Physician _____Date of Birth _____ Sex: F/ M

Check the Yes or No Box appropriately	**Yes**	**No**
1. Are you in good health?		
2. Has there been a change in your health in the last year?		
3. Are you under the care of a physician? If yes, explain		
4. Have you ever been hospitalized, had major operations, or serious illness in the past 5 years? If yes, explain		
5. My last dental exam was on?		
6. Are you in pain now?		
7. Are you taking any prescription or any over the counter medications? If yes, please list		
8. Are you allergic to any medications, latex, or foods? If yes, list		
9. Have you ever had treatment for a tumor or growth in or on the mouth, head, or neck? If yes, when		
10. Are you wearing contact lenses?		
11. Have you ever had abnormal bleeding after a cut or tooth extraction?		
12. Do you or have you used cigarettes or chew tobacco?		
13. Do you or have you used recreational drugs, heroin, or marijuana?		
14. Do you or have you used diet medication, supplements, herbs, or vitamins?		
15. Have you been treated for alcohol abuse?		
16. Do you have a family history of diabetes, heart disease, or cancer?		
Females:		
17. Are you or could you be pregnant? If yes, estimated due date is		
18. Are you taking birth control pills? **Antibiotics may interfere with your birth control decreasing their effectiveness.		
19. Are you currently breastfeeding?		

Please check the appropriate box

	Yes	No
Heart disease	☐	☐
Heart murmur	☐	☐
Angina/ Chest pain	☐	☐
Congestive Heart Failure	☐	☐
Shortness of breath	☐	☐
Cardiac pacemaker or other implanted device	☐	☐
Mitral valve prolapse	☐	☐
Rheumatic fever	☐	☐
Liver disease	☐	☐
Hepatitis	☐	☐
Stroke	☐	☐
High blood pressure	☐	☐
Dizziness, seizures, or fainting spells	☐	☐
Epilepsy	☐	☐
Kidney disease or Dialysis	☐	☐
Diabetes	☐	☐
Eye surgery/ glaucoma	☐	☐

	Yes	No
Respiratory disease	☐	☐
Asthma	☐	☐
Sleep Apnea	☐	☐
Tuberculosis	☐	☐
Other lung disease	☐	☐
Stomach or intestinal disease	☐	☐
Thyroid/ adrenal disease	☐	☐
Artificial joints	☐	☐
Arthritis	☐	☐
Jaw joint pain/ dysfunction	☐	☐
Osteoporosis	☐	☐
Sexually transmitted disease	☐	☐
AIDS/ HIV+	☐	☐
Blood disease	☐	☐
Blood transfusion	☐	☐
Bleeding disorder	☐	☐
Cancer	☐	☐
Radiation therapy/ Chemotherapy	☐	☐
Sinusitis	☐	☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my oral surgeon or any other member of their staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of patient, parent, or guardian Date

_____

Signature of Doctor

Suburban Oral Surgery and Implant Center
Office Policies

A. Appointments

1. All appointments will be confirmed three business days prior. It is the patient's responsibility to provide the office with a working telephone number. If the patient provides a non-working telephone number and does not contact the office 48 hours prior to the scheduled appointment, the appointment will be automatically cancelled.

2. We require a 48 hour notice when canceling or rescheduling an appointment. Failure to give a 48 hour notice may result in a missed appointment fee of $100.00.

3. If you are scheduling a procedure that requires one or more hours, a non-refundable deposit may be required. The deposit will be applied to your balance.

4. All minors must be accompanied by a parent or guardian. The parent or guardian of a minor is responsible for any incurred charges.

5. It is the patient's responsibility to inform this office of any changes in their personal information (insurance carriers, address changes, phone number change, etc.).

B. Payment

1. All estimated co-pays/deposits are due on or before the date of service. **Any deposit made is an estimate of your co-insurance and may reflect your final out-of-pocket expense.** It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.

2. If your estimated deposit exceeds $1000.00 or your procedure requires surgical supplies, you will be required to make a down payment of $250.00 one week prior to your appointment.

3. Once all insurance payments are received, a statement will be sent for any remaining balance due. Any outstanding balance past due 30 days will accrue a late fee.

4. If your service is not covered by insurance, full payment is due at the time of service. We accept Visa, MasterCard, Discover and American Express.

5. We accept CareCredit®, a third party financing program that can help pay for procedures not fully covered by your insurance. CareCedit®can assist you in setting up a payment plan for your treatment. Go to carecredit.com to see if you qualify and learn more about the program.

C. Insurance

1. As a courtesy, we will verify benefits with your insurance carrier(s). **Benefits quoted to us over the phone are not a guarantee of payment.** Benefits will be subject to eligibility at the time services are rendered, plan limitations and other exclusions.

2. We will bill your dental/medical insurance company for all covered procedures. There is a $5.00 processing fee (for filing fee, x-ray copies, etc.) to have our office bill your insurance companies.

3. If your insurance requires a referral from your primary care physician/dentist to see a specialist, the patient is responsible for acquiring and keeping the referral current. The patient must have the referral at our office prior to scheduling any major oral surgery appointment. You may have it faxed, mailed or delivered to the office. We are unable to obtain a referral for you.

I have read and understand these office policies _____ _____

(initials) **(date)**

HIPAA Notice of Privacy Practices

Suburban Oral Surgery and Implant Center
580 East Boughton Road, Suite B
Bolingbrook, IL 60440 (630)
972-1599

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations 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 or future physical, dental or mental health or condition and related dental or health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your dentist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care service to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your dental/health care with a third party. For example, your PHI may be provided to a dentist from whom you have been referred to ensure that our dentist has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your dental care services.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your dentist's practice. The activities include, but are not limited to, quality assessments activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your PHI , as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. *These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 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 have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy records or any information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply. If your dentist does not agree to the restriction you request, you have the right to use another dental care professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location.

You have the right to a paper copy of the Notice of Privacy Practices at any time upon request.

You have the right to request that your dentist amend your PHI. Please be advised, however, that this practice is not required to agree to amend your PHI. If your request has been denied, you will be provided with an explanation of our reason(s) and information about how you can disagree with the denial.

You have the right to receive an accounting of disclosures of your PHI made by this practice. We reserve the right to change the terms of this notice at any time.

Complaints about your privacy rights, or how this practice has handled your PHI should be directed to: Office for Civil Rights U.S. Department of Health and Human Services at 233 N. Michigan Ave., Suite 240 Chicago, IL 60601. This notice was published and becomes effective on/or before February 27, 2005.

Notice of Privacy Practice Acknowledgement

Suburban Oral Surgery
and Implant Center
(630) 972-1599

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my care.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and understand the Notice of Privacy Practices. I also understand that I am entitled to a copy of the Notice of Privacy Practices.

I understand that I may request, in writing, how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations.

Patient Name: _____

Patient Signature: _____
Signature of Parent or Guardian if patient is a minor

Date: _____