PLEASE PRINT

PATIENT REGISTRATION

OFFICE USE ONLY
DATE UPDATED _____
_____
_____

REFERRED BY _____ DATE _____

NAME OF PATIENT _____
LAST FIRST MIDDLE NICKNAME

ADDRESS _____
STREET APT. # CITY STATE ZIP CODE

PHONE _____ AGE _____ DATE OF BIRTH _____ SEX _____

FATHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE #

HOME ADDRESS _____
STREET APT. # CITY STATE ZIP PHONE

S.S. No. _____ FATHER S.S. No. _____ MOTHER

MOTHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE #

HOME ADDRESS _____
STREET APT. # CITY STATE ZIP PHONE

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE? ☐ YES ☐ NO

LIST THEIR NAMES _____

NAME OF FRIEND OR NEIGHBOR WHO CAN REACH YOU IN CASE OF EMERGENCY _____

ADDRESS _____ PHONE _____
STREET APT. # CITY STATE ZIP

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD (MASTER CARD, VISA)

IS PATIENT COVERED BY INSURANCE? IF SO _____
NAME OF INSURANCE COMPANY POLICY OR I.D. #

_____
SUBSCRIBER NAME

The policy in our office, is the parent who requests treatment for the child is responsible for all fees for services rendered.

_____ _____
Signature Of Parent Requesting Care Date

MEDICAL HISTORY (LONG FORM)

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? YES NO
2. Has there been any change in your general health within the past year? YES NO
3. My last physical examination was on _____
4. Are you now under the care of a physician? YES NO
   a. If so, what is the condition being treated? _____
5. The name and address of my physician is _____
   _____
   _____
6. Have you had any serious illness or operation? YES NO
   a. If so, what was the illness or operation? _____
7. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO
   a. If so, what was the problem? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves YES NO
   b. Congential heart lesions YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) YES NO
      1) Do you have pain in chest upon exertion? YES NO
      2) Are you ever short of breath after mild exercise? YES NO
      3) Do your ankles swell? YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
      5) Do you have a cardiac pacemaker? YES NO
   d. Allergy YES NO
   e. Sinus trouble YES NO
   f. Asthma or hay fever YES NO
   g. Hives or a skin rash YES NO
   h. Fainting spells or seizures YES NO
   i. Diabetes YES NO
      1) Do you have to urinate (pass water) more than six times a day? YES NO
      2) Are you thirsty much of the time? YES NO
      3) Does your mouth frequently become dry? YES NO
   j. Hepatitis, jaundice or liver disease YES NO
   k. Arthritis YES NO
   l. Inflammatory rheumatism (painful swollen joints) YES NO
   m. Stomach ulcers YES NO
   n. Kidney trouble YES NO
   o. Tuberculosis YES NO
   p. Do you have a persistent cough or cough up blood? YES NO
   q. Low blood pressure YES NO
   r. Venereal disease YES NO
   s. AIDS YES NO
   t. Sjogren's syndrome or any other autoimmune disease. YES NO
   u. Other _____
9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO
   a. Do you bruise easily YES NO
   b. Have you ever required a blood transfusion? YES NO
   If so, explain the circumstances _____
   _____
10. Do you have any blood disorder such as anemia? YES NO
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
12. Are you taking any drug or medicine? YES NO
    If so, what? _____

13. Are you taking any of the following:

a. Antibiotics or sulfa drugs	YES	NO
b. Anticoagulants (blood thinners)	YES	NO
c. Medicine for high blood pressure	YES	NO
d. Cortisone (steroids)	YES	NO
e. Tranquilizers	YES	NO
f. Antihistamines	YES	NO
g. Aspirin	YES	NO
h. Insulin, tolbutamide (Orinase) or similar drug	YES	NO
i. Digitalis or drugs for heart trouble	YES	NO
j. Nitroglycerin	YES	NO
k. Oral contraceptive or other hormonal therapy	YES	NO
l. Other _____		

14. Are you allergic or have you reacted adversely to:

a. Local anesthetics	YES	NO
b. Penicillin or other antibiotics	YES	NO
c. Sulfa drugs	YES	NO
d. Barbiturates, sedatives, or sleeping pills	YES	NO
e. Aspirin	YES	NO
f. Iodine	YES	NO
g. Codeine or other narcotics	YES	NO
h. Other _____		

15. Have you had any serious trouble associated with any previous dental treatment? YES NO
If so, explain _____

16. Do you have any disease, condition, or problem not listed above that you think I should know about YES NO
If so, explain _____

17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO

18. Are you wearing contact lenses? YES NO

WOMEN

19. Are you pregnant? YES NO

20. Do you have any problems associated with your menstrual period? YES NO

21. Are you nursing? YES NO

$2 per month may be added on accounts past due.

CHIEF DENTAL COMPLAINT:

_____
SIGNATURE OF PATIENT

ADA American Dental Association

_____
SIGNATURE OF DENTIST

CONTACT UPDATES:

Home Phone: _____ Date: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Would you like us to: ☐ Email ☐ Text ☐ None

Protecting Your Confidential Health Information is Important to Us

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s):_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

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

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Dr. MICHAEL R. ERRICO

3315 ALGONQUIN RD., SUITE 105 • ROLLING MEADOWS, IL 60008 • (847) 788-0808

Michael R. Errico, DDS, PC & Associates
Financial Policies

1. Statements are mailed out each month. Payments are due 20 days after the statement date unless other arrangements have been made in advance.

2. If no payment is received by the next statement date, a late fee of $2.00 may be assessed to the account.

3. Accounts that have not received any payments or acknowledgement for 4 consecutive months will be referred to a collection agency. A collection fee of 30~40% of the current outstanding balance will be added to the account. This service charge is non-adjustable and will be added to your outstanding balance being sent to the collection agency. In addition, any bounced or non-sufficient fund checks will receive a $25.00 penalty charge.

4. As a courtesy to our patients, one no-show appointment is allowed per year. All other no-show appointments may be charged a minimum of $35 per hour failed appointment fee. A no-show is considered an appointment to which a patient does not come and did not call to cancel 24 hours before the time of the appointment. No-show appointment fees are expected to be paid and will not be adjusted off of your account. When a patient makes an appointment, it is their responsibility to attend that appointment. Every attempt is made 1~2 days prior to inform a patient of their obligation, but sometimes we are not always able to contact the patient directly. A confirmation call is only a courtesy.

5. All patients are responsible to know and monitor their own insurance benefits. Important things to pay attention to are co-payments, fee for service, deductibles and services not covered by your insurance plan. Our office only uses non-metallic composite materials. Most insurance companies only pay for metallic materials on posterior teeth. They also may pay for different crown materials than we use.

6. Our office will file claims if you are insured. All co-insurance payments and/or deductibles will be payable at time of service unless previous arrangements have been made in advance. I realize that I am responsible for any procedure not covered by my insurance plan.

7. Patients will be charged for dental record copying following the guidelines set by the American Dental Association (ADA).

8. All accounts must be paid in full at the finish of treatment, unless further financial arrangements have been made.

I understand the above stated financial policies of Michael R. Errico, DDS, PC & Associates. I have been given an opportunity to have all my questions answered regarding these policies.

X_____

Patient Informed

Date _____

_____

2/2012

INSURANCE INFORMATION

PRIMARY COVERAGE

Mail Claims To: _____
(Name of insurance company)

_____
(Complete mailing address)

Patient Information: _____
Last Name First Name M.I. Birthdate

Name of Insured: _____
Last Name First Name M.I. Birthdate

ID#: _____ Group#: _____

SECONDARY COVERAGE

Mail Claims To: _____
(Name of insurance company)

_____
(Complete mailing address)

Patient Information: _____
Last Name First Name M.I. Birthdate

Name of Insured: _____
Last Name First Name M.I. Birthdate

ID#: _____ Group#: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize Michael R. Errico, DDS, PC & Associates to furnish information to insurance carriers listed above concerning my treatments. I hereby assign to the physician all payments for dental services rendered to me or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. This includes but is not limited to missed appointment fees, late co-pay fees and re-billing fees. I also agree that any expense incurred by Michael R. Errico, DDS, PC & Associates to collect the unpaid balance of the bill, including collection agencies, attorney fees, court costs and other expenses, will be added to the bill if such additional services are required. In the event that my account is turned over for collections, information that is necessary for collection purposes will be forwarded to our professional collection company.

Signed _____ Date _____
(Insured person/Parent/Guardian)

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

I hereby authorize Michael R. Errico, DDS, PC & Associates to release to the insurance company(ies) listed above, any/all information acquired in the course of my or my dependent's examination and treatment.

Signed _____ Date _____
(Patient/Parent/Guardian)

Michael R. Errico, DDS, PC & Associates

Disclosure of Dental Information

Name: _____ Date of Birth: _____

Patient confidentiality is of utmost importance to us and we prefer to give test results or other information directly to the patient. However, occasionally we are asked to release information to another individual.

Please choose from the following options:

O I want my test results/healthcare information reported ONLY directly to me.

O Dr. Michael Errico's staff has my permission to speak to myself or one of the following individuals listed below:

	Name	Phone #	Relationship
1.			
2.			
3.			

~ May we leave personal healthcare information on your answering machine? ___Yes ___No

~ May we contact you at work? ___Yes ___ No

If Yes, please provide your direct work number: _____
(Please print clearly)

Signature: _____ Date: _____

MODEL RELEASE CONTRACT

This agreement is entered between _____ *(model)*, Michael R. Errico, D.D.S., P.C. and those acting on his behalf, for usage of photographs.

I hereby grant to Michael R. Errico, D.D.S., P.C., and those acting on his behalf, their heirs, legal representatives, and assigns, and those acting with their authority and permission, the irrevocable and unrestricted right and permission to take, copyright in his and her own name or otherwise, and use, reuse, publish, and republish photographic portraits or pictures of me or in which I may be included, in whole or in part, composite or distorted in character or form, without restriction as to changes or alterations, in conjunction with my own or a fictitious name, or reproductions thereof, made through any medium, and in any and all media now or hereafter known for illustration, promotion, art, editorial, advertising, or any other purpose whatsoever. I also consent to the use of any published matter in conjunction therewith.

I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge, and agree to save harmless Michael R. Errico, D.D.S., P.C. and those acting on his behalf, their heirs, legal representatives, and assigns, and all persons acting under their authority and permission or those for which they are acting, from any liability by virtue of blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said picture or in any subsequent processing thereof, as well as any publication thereof.

Michael R. Errico, D.D.S., P.C. and those acting on his behalf, their heirs, legal representatives and assigns and those acting with their authority and permission agree(s) not to use or allow images of the model in whole or in part to be used in ways that would slander, embarrass, attack, or any other potentially defamatory manner directed onto the character or person of the model.

I hereby warrant that I am of full age or am the legal guardian of the model and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives and assigns.

_____ _____

Model signature Date

Patient Agreement

I hereby assign all dental benefits, to include all private insurance and other health plans with dental coverage, to Dr. Michael R. Errico and Associates.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my dental/medical records and release of information necessary to secure payment from said insurance company.

In the event that I personally receive payment by my insurance company, whether it be by check or deposit for the services to be rendered to me by Dr. Michael R. Errico and Associates, I hereby agree to forthwith and instanter deliver said check to Dr. Michael R. Errico and Associates, with my endorsement for deposit and payment for services rendered to me by Dr. Michael R. Errico and Associates.

If there is a balance due on my account after receipt of insurance payment, I agree to pay the full amount of the check within ten(10) days of receipt of the check.

I understand that my dental insurance is based upon a contract between myself and/or my employer and the insurance company. I understand that Dr. Michael R. Errico and Associates practice is in no way associated with the contract between myself and my insurance company. Therefore, I understand that I am responsible for the terms of benefits of my insurance.

I understand that submitting claims to the insurance company is a courtesy that is being provided to me by Dr. Michael R. Errico and Associates.

I understand that should I fail to comply with set agreement and/or fail to pay any balance owed to Dr. Michael R. Errico and Associates that I am subject to filing of a civil lawsuit to collect the fees for services rendered to me by Dr. Michael R. Errico and Associates and that I will be liable for any and all reasonable Attorney fees in connection with the collection efforts and any and all court costs incurred by Dr. Michael R. Errico and Associates.

I also understand that in the event I deposit or cash any insurance check that I may be subject to the criminal charges for theft of services.

Any and all complaints will be filed in the Circuit Court of Cook County, State of IL

I understand the contents of this Patient Agreement and I agree to honor them.

_____ _____

(Patient Name) (Date)