Patient Registration

How did you learn about our office?

☐ Convenient Location ☐ Newspaper Ad ☐ Social Media (which)? _____ ☐ Insurance ☐ Mailing

☐ Previous Patient (Name)_____ ☐ Friends/Family (Name)_____ ☐ Other _____

Patient Information

Patient is: ☐ Policy Holder ☐ Responsible Party Date: _____

First Name:_____ Last Name: _____

Address:_____ Address 2: _____

City:_____ State / Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext:_____ Cellular: (_____) _____

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

Birth Date:_____ Age: _____

Social Security Number:_____ Driver's License Number: _____

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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Responsible Party (if someone other than patient)

Name of Person Responsible for this Account: _____

Address:_____ Address 2: _____

City:_____ State / Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_ Ext:_____ Cellular: (____) _____

Birth Date:_____ Social Security Number:_____ Driver's License Number: _____

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

Signature of Responsible Party: _____

OVER PLEASE

Pinnacle Dental Group

Primary Insurance Information

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

Insured Social Security Number: _____ Insured Birth Date: _____

Employer: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Insurance Company: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Remaining Benefits: _____.00 Remaining Deductible: _____.00

Secondary Insurance Information

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

Insured Social Security Number: _____ Insured Birth Date: _____

Employer: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Insurance Company: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Remaining Benefits: _____.00 Remaining Deductible: _____.00

Patient Dental History

Name:_____ Date _____

Name of Previous Dentist and Location: _____

Date of last exam: _____ Were X-rays taken? ☐ Yes ☐ No

Is there anything about your smile you would like to change or improve? ☐ Yes ☐ No

If yes, what would you like to change? _____

How often do you brush? _____

How often do you floss?_____

Do you use tobacco products? ……. ☐ Yes ☐ No

If yes, what kind?_____How frequently and for how many years? _____

Do your gums bleed while brushing or flossing?……. ☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids/foods?…….. ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour liquids/foods?…….. ☐ Yes ☐ No

Do you feel pain to any of your teeth?……. ☐ Yes ☐ No

Do you have any sores or lumps in or near your mouth? …… ☐ Yes ☐ No

Have you had any head, neck or jaw injuries? …… ☐ Yes ☐ No

Have you ever experienced any of the following problems in your jaw:

Clicking? …… ☐ Yes ☐ No

Pain (joint, ear, side of face)? …… ☐ Yes ☐ No

Difficulty in opening or closing? ……... ☐ Yes ☐ No

Difficulty in chewing? …… ☐ Yes ☐ No

Do you have frequent headaches? ……... ☐ Yes ☐ No

Do you clench or grind your teeth? …… ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? …… ☐ Yes ☐ No

Have you ever had any difficult extractions in the past? ……. ☐ Yes ☐ No

Have you ever had any prolonged bleeding following extractions? …… ☐ Yes ☐ No

Have you had any orthodontic treatment? …… ☐ Yes ☐ No

Have you had any periodontal (gum disease) treatment? ……. ☐ Yes ☐ No

Do you wear dentures or partials? …… ☐ Yes ☐ No

If yes, date of placement _____

Have you ever received instructions regarding the care of your teeth and gums? ☐ Yes ☐ No

Medical History

Patient 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.

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A _____

Are you taking any medications, including non-prescription drugs? ☐ Yes ☐ No ☐ N/A

If Yes, please list the medications you are taking. _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A _____

Do you or have you had a problem with alcohol or drug abuse? ☐ Yes ☐ No ☐ N/A _____

Do you use or have you used tobacco products? ☐ Yes ☐ No ☐ N/A _____

Are you on a special diet? ☐ Yes ☐ No ☐ N/A _____

Women Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic or have you had a reaction (swelling, rash, itching) to any of the following?

☐ Aspirin ☐ Penicillin or other antibiotics ☐ Codeine ☐ Acrylic
☐ Metals/Jewelry ☐ Latex/rubber products ☐ Local anesthetics ☐ Other _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital heart Disorders	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A – Not answered by patient

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

☐

Pinnacle Dental Group

Our Financial Policy

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care, and convenient financial arrangements are a part of successful, predictable treatment results. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patients' financial capabilities. Please read, sign and return the following:

Payment

Payment of patient portion is due in full at the time of service unless prior financial arrangements are made. Any balance not paid by your insurance provider is the patient's (or responsible party's) responsibility.

We offer several payment options:

1. We accept Cash, Checks, Visa and Mastercard.
2. We offer pre-payment discounts.
3. We offer monthly payment plans in accordance with the office credit guidelines.

Insurance

Our office is committed to helping our patients maximize their benefits. As you may be aware, medical and dental insurance is becoming extremely complex. We are always available to answer your questions, however, ***your insurance policy is a contract between you and your insurance company****,* and as a dental provider, we are not part to that agreement. *Your patient portion must be paid* at *the time of service.* We ask our patients to provide us with complete dental insurance information. As a service to our patients, we will bill insurance companies for services and allow them 30 days to render payment in full. *After 60 days you are responsible for the entire balance and it will be due in full.* The quality of insurance *policies varies* greatly; therefore, we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.

If you have a secondary insurance plan, we will submit a claim to your secondary insurance provider. You will be responsible for any balance remaining after primary insurance payment, and your secondary insurance may reimburse you in pan or in full, as per your contract with them.

Minors

Payment for services for the treatment of minors can be made by check, cash or credit card and is the responsibility of the adult accompanying that minor.

Collection Fees

Fees incurred to collect payment will be billed to, and payable by, the patient's account holder.

Cancellation Policy

If you need to cancel an appointment, please give at least 48 hours-notice so we may offer your appointment time to another patient. ***A $75.00 cancellation fee may be applied to your account for broken appointments or short notice cancellations.*** If your appointment is on Monday, please let us know by Friday, 12 pm of your cancellation.

Financial Consent

The patient (accou**nt holder) agrees to be fully responsible for total payment of treatment performed in* this ***office.

I understand and agree to this Financial Policy and Agreement

_____ _____

Signature of patient/responsible party Date

Pinnacle Dental Group

Notice of Privacy Practices Acknowledgement & Patient Consent to Disclose

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to rue under the Health Ins. Portability and Accountability Act of 1996 **(HIPPA).** I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- Conduction of standard healthcare operations;
- Confirmation of appointments/messages may be left on voicemails to deliver pre-operative instructions. These instructions may also be left with any person that answers the phone number provided to this office.

I have also been given the right to review and secure a copy of your ***Notice of Privacy Practices*****,** which contains a *more* complete description of the uses and *disclosures* of my protected health information and my rights under *HIPPA.* I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that 1 have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction(s).

I authorize information in regards to my health/accounting issues to be discussed with the following person/people; **(PLEASE PRINT)**

1. _____Relationship: _____
2. _____Relationship: _____

At any time 1 have a right to change this request I understand that it must be submitted in writing.
If unable to reach me I authorize release of information via: **EMAIL_____OFFICE____HOME____CELL_____**

Print Name of Patient:_____***Date:***_____

Relationship to Patient: Self:_____***Parent***_____***Guardian***_____***Other***_____

Signature _____

13530 S. Route 59, Suite 120, Plainfield, IL 60544
www.pinnacledentalgroup.com (815) 436-1530 info@pinnacledentalgroup.com

Cancellation and No-Show Appointment Policy

Dr. Justina and her staff at Pinnacle Dental Group have been dedicated to providing you with the highest quality dental care in a timely manner. When you make an appointment with our office, that time is reserved especially for you. We ask that you understand that a last minute cancellation or "no-show" adversely affects our ability to provide prompt attention to our patients and does not allow us enough time to accommodate another patient who is currently on our waiting list. If you are unable to make your appointment time, we respectfully ask that you notify our office at least 48 hours in advance.

- If you fail to give at least 48 hours-notice for your appointment, a missed appointment will be documented in the patient's chart and you will be billed as follows:

- 1st missed appointment/year: Fee will be waived
- 2nd missed appointment and beyond: $75.00 fee will be applied for the missed visit

- If you fail to show up for an appointment, without notification, a failed appointment will be documented in the patient's chart and you will be billed as follows:

- 1*t failed appointment: Fee will be waived
- 2' d failed appointment and beyond: $75.00 fee will be applied for the failed visit

If you request for Monday appointment, you must let us know of your cancelation by Friday 12 pm in order to avoid $75.00 fee.

We appreciate your understanding regarding this matter and look forward to providing the best dental care for you.

Patient Name (please print) _____

Patient/or Guardian of patient (signature) _____

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Covid-19 Acknowledgement of Risk Form

Our goal is to provide a safe environment for our patients and staff. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your clinicians may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected with COVID-19 is challenging due to limited availability for virus testing.

Due to frequency and timing of visits by other dental patients, the characteristics of the virus, and the nature of dental procedures, there may be an elevated risk of you contracting the virus by being in a dental office.

Dental procedures create aerosols and droplets, which is how the virus is spread. The aerosols can linger in the air for hours, allowing for transmission of the disease through respiration, especially if a person is not wearing any respiratory protection (a mask).

You cannot wear a protective mask over your mouth during dental treatment as your clinicians need access to your mouth to perform dental procedures. This may leave you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the notice above and understand and accept that there may be an increased risk of contracting the COVID-19 virus in the dental office and during dental treatment.

I also acknowledge that I could contract the COVID-19 virus from outside of the dental office and unrelated to my dental visits here.

I have read and understand the information stated above:

Name: _____ Date: _____