



Maple Shade now allows you to fill out your patient forms online and submit them. Please fill out all paper work including the health history form and children's form if it applies and hit the submit button. Please also check the box by the office you are scheduled at.

- Dunlap (11825 N. Knoxville Ave Dunlap IL 61525)**
- East Peoria Office (1001 Illini Dr. East Peoria, IL 61611)**



NOTICE OF PRIVACY PRACTICES

Date of last revision: Feb. 23, 2005

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

THIS NOTICE APPLIES TO ALL OF THE RECORDS, OF YOUR CARE, GENERATED BY MAPLE SHADE REGIONAL MULTI-SPECIALTY CENTER WHETHER MADE BY THIS PRACTICE, OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to any health care professional authorized to enter information into your chart (dentists, hygienists, assistants, etc...), all areas of the practice (front desk, administration, business associates, billing and collections, etc...).

Provision of Notice: The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) The Practice provides its Notice of Privacy Practices to every patient with whom it has a direct treatment relationship The Notice is provided on later than the date of the first treatment to the patient after Feb.23, 2005. The Practice makes its Notice available to any member of the public to enable prospective patients to evaluate the Practice's privacy policy when making his or her decision regarding whether to seek treatment from the Practice.

We understand that your medical information and records are personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

Medical Information: We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore, we may, and most likely will, disclose medical record(s), prescriptions, requests of lab work and treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside of the Practice who may be personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

Payment: We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information; about treatment you received at the Practice to obtain a treatment you are going to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Appointment and recall reminder: We may ask that you sign in writing at the front desk, a "sign-in log" with the accurate arrival time of your appointment. We may use and disclose medical information to contact you as a reminder that you have an appointment for dental care with the Practice or that you are due to receive periodic exams from the Practice. This contact may be by phone or by mail and may involve the leaving of a message on your answering machine, or otherwise could (potentially) be received or intercepted by others.

OVER PLEASE →

Emergency Situations: In addition we may disclose medical/dental information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Required by Law: We will disclose medical information about you when required to do so by federal, state, and local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness. We will only make this disclosure if you agree or when required or authorized by law.

Changes to This Notice: We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for dental information we already gave you as well as any information we may receive from you in the future.

Submitting Insurance: As a benefit to our patients, our Practice submits insurance claims on your behalf. We do disclose information to insurance companies for proper protocol. If at any time you feel that you do not wish for us to disclose information, you do have the right to submit your own claim to your insurance company. Payment will then be due in full at the time of service.

I hereby confirm that I have read the following and know and understand all of the above information. If I have any questions or concerns regarding these issues, I will address the proper individuals for additional information.

Patient/Guardian

Signature _____ Date _____

Maple Shade Dental Orthodontic Patient Registration

Today's Date: _____

PATIENT INFORMATION

Patient's Name _____ Nickname _____ Sex: M F Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

School or Employer _____ Grade or Occupation _____

Hobbies _____

How Did You Hear About Us? _____ Other Family Members Or Friends Seen By Us _____

Sibling or Children : Yes No Name/Age _____ Name/Age _____ Name/Age _____

RESPONSIBLE PARTY INFORMATION

Responsible Party _____ Relationship to Patient _____ Marital Status S M W D

Home Address _____ City _____ State _____ Zip _____

Own or Rent? _____ How Long At This Address? _____ Mail Address (if different from above) _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ # of Years Employed _____

Employer Address _____ Work Phone _____

Spouse's Name _____

Employer _____ Occupation _____ # of Years Employed _____

Employer Address _____ Work Phone _____

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name _____

Insured's Employer _____ Employer Address _____ Employer Phone _____

Insurance Company _____ Group # _____ Insurance Phone _____

Insurance Address _____ Insurance Fax or Website _____

Do You Have Dual Coverage? YES NO

Secondary Insured's Name _____

Insured's Employer _____ Employer Address _____ Employer Phone _____

Insurance Company _____ Group # _____ Insurance Phone _____

Insurance Address _____ Insurance Fax or Website _____

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative Not Living with Patient _____ Relation _____ Home Phone _____

Address _____ Work Phone _____ Cell Phone _____

MEDICAL HISTORY

Physician _____ Date Of Last Visit _____ Current Medical Status: Good Fair Poor

Address _____ Phone _____

Please circle YES or NO (If YES, please specify.)

YES NO Are you taking any prescription or over-the-counter medication (s)? _____

YES NO Do you have any allergies (food, metal, plastic, latex or drug)? _____

YES NO Do you have a history of major illness, hospitalization or serious accident? _____

Please circle any of the medical conditions that you have had or currently have.

- AIDS, Diabetes, Handicaps/Disabilities, Kidney Disorders, Rheumatic Fever, Arthritis, Dizziness/Fainting, Heart Problems, Liver Disorders, Sensory Difficulties, Asthma, Drug/Alcohol Abuse, Hepatitis, Musculoskeletal Disorders, Speech problems, Birth Defects, Endocrine Disorder, Herpes, Pneumonia, Tobacco Habit, Blood Disorders, Epilepsy, High or Low Blood Pressure, Psychological/psychiatric conditions, Tuberculosis, Bone Disorder, Gastrointestinal Disorder, Immunological Disorder, Respiratory Disorder/ Difficulties, Tumor or Cancer

Are there any other medical/ clinical/ family conditions or history that we should be aware of?

If women, are you pregnant? YES, Week # _____ NO Nursing? YES NO

Dental History

Dentist _____ Date of last cleaning _____ Current Dental Status: Good Fair Poor

Address _____ Phone _____

WHAT CONCERNS YOU MOST ABOUT YOUR TEETH, BITE OR SMILE? WHY ARE YOU HERE TODAY?

YES NO Are you presently in any dental pain or discomfort? Any sensitivity to pressure, hot, cold or sweet? _____

YES NO Have you had any serious or difficult problems with previous dental work? _____

YES NO Any history of trauma to the face, teeth, jaw or chin? _____

YES NO Do you gums bleed? Have you been told you have, or been treated for gum problems, attachment/bone loss or periodontal disease?

YES NO Have you ever experienced pain, discomfort or noise in you jaw joint? _____

YES NO Have you been informed of any congenitally missing or supernumerary (extra) teeth? _____

YES NO Any family members with history of jaw surgery? _____

Do you have (had) any of the following habits? (Please check all that apply.)

- Chew Snuff/ Tobacco, Lip Sucking/ Biting, Nail Biting, Thumb or Finger Sucking, Clenching/ Grinding, Mouth Breathing, Sleep Apnea, Tongue Thrust or Lisp

YES NO Have you ever been evaluated for braces (or had braces) before? _____

SIGNATURE

I certify that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. I understand that it is my responsibility to inform this office of changes medical/dental status. I authorize the orthodontic staff to perform any necessary services for diagnosis and treatment with my informed consent. I also relinquish any and all right to the use of photographs and records made in the process of examination, treatment and retention by Maple Shade Dental (including, but not limited to publication in professional journals, research or education). I understand that late payments over 30 days are subject to a \$10.00 finance fee. If applicable, I authorize insurance payment of orthodontic benefits directly to this office as well as authorize release of all information necessary to secure payment. I agree to pay any fees not paid by insurance and all collection fees, should my account become delinquent. Finally, I authorize this office to verify my credit history prior to extending credit to me for any treatment fees, and that this office may use the services of one or more credit reporting agencies.

Signature of Patient/Parent or Legal Guardian _____ Date _____

Financial Policy for Maple Shade Dental Group, Ltd.

It is the goal and commitment of our dentists and staff to provide you with the highest level of dental care available, for years to come. In this spirit, we believe it is possible to avoid miscommunications by having clear expectations and therefore have outlined the following policies regarding your patient account:

1. PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

We accept Cash, Checks, Credit and Debit Cards. *NSF checks will cost the patient appropriate additional fees.*

Initial _____

2. FINANCING IS AVAILABLE UPON APPROVAL. When work is needed now and low monthly payments would be more convenient, inquire about how we can assist you with low interest and interest free financing.

Initial _____

3. IF YOU HAVE INSURANCE, WE ARE HAPPY TO SUBMIT CLAIMS TO MOST CARRIERS.

Payment for deductibles and out of pocket expenses are estimated and due at the time of service.

- A. We can only *ESTIMATE* what your insurance will cover. Therefore, the account holder is responsible for out of pocket expenses at the time of service and all unpaid balances after insurance has either paid their portion, or determined otherwise.
- B. Any balance remaining after insurance is complete, it will be due *within 30 days*. Likewise, if an insurance company pays more than estimated, we will refund the excess paid by you or apply it to a current balance due on your account. You may also leave it on account for future use if you so desire.
- C. In the event that the insurance carrier makes an overpayment error, we will refund payment to them.
- D. The patient is responsible to inform our office of any changes regarding their insurance provider or job status that might affect coverage or claim filing.
- E. Most insurance companies require the insured's *social security and date of birth*. If you do not wish to provide this information, we will be unable to file claims on your behalf. Therefore, payment in full will be due at the time of service.
- F. Signature below will be used as *Signature on File* for claims submission. It may also be used for Credit Application and Debit/Credit Card payments initiated by the account holder via phone.

Initial _____

3. OUTSTANDING BALANCES ARE DUE WITHIN 30 DAYS OF THE STATEMENT DATE.

Initial _____

4. TO AVOID BILLING FEES AND MONTHLY FINANCE CHARGES...

Please call our office promptly so we can facilitate a resolution to any/all of your concerns.

Initial _____

5. MISSED APPOINTMENT FEES WILL BE CHARGED.

Please call our office at least 24 hours in advance to cancel or reschedule an appointment.

Initial _____

I understand that in signing this form I take full responsibility for all fees incurred by Maple Shade Dental Group, Ltd., on behalf of myself, as well as those family members listed under my account. In addition to the outstanding balance, I further acknowledge that I am responsible for collection and attorney fees should the account be turned over to collections.

Patient Name _____

Patient/Guardian Signature _____

Date _____