INNOVATION DENTAL
By Alex J. Schillinger, DMD
prevent • restore • renew

717 Insight Avenue, Suite 200, O'Fallon, IL 62269
618-277-6550 (Office) 618-800-2906 (Fax)

Please help us by providing the following confidential information.

Patient Information

Name (last, first, middle):_____Preferred_____

Date of Birth_____ Sex : M_____ F_____ SS#_____

Email address_____ How did you hear about our office?_____

Home Address:_____ City_____ State____ Zip_____

Circle preferred phone number to use

Home Phone_____, Work_____ Cell_____

Employer_____ Phone #_____ Occupation_____

Emergency Contact Name _____ Phone #_____

Primary Dental Insurance Information

Policy Holder Name_____ Relationship to Patient_____

Employer_____ Phone #_____

Birth date_____ SS# or SID_____ Group #_____

Insurance Company_____Address_____

City_____ State_____ Zip_____ Phone #_____

Secondary Dental Insurance (if applicable)

Policy Holder Name_____ Relationship to Patient_____

Employer_____ Phone #_____

Birth date_____ SS# or SID_____ Group #_____

Insurance Company_____Address_____

City_____ State_____ Zip_____ Phone #_____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Schillinger of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Patient's Signature _____ Date_____

MEDICAL HEALTH HISTORY

CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

Yes No Are you in good health?

Yes No Has there been a change in your health within the last year?

Explain:_____

Yes No Have you been hospitalized or had a serious illness in the last 2 years?

Explain:_____

Yes No Are you being treated by a physician now? Explain: _____

Name of your physician: _____ Date of last Medical Exam: _____

CHECK THE FOLLOWING IF YOU HAVE OR HAVE HAD SERIOUS PROBLEMS WITH:

____Heart attack or heart disease (circle)
____Heart murmur
____Heart Valve replacement
____Stroke
____Blood thinner
____High Blood Pressure
____Low Blood Pressure
____Artificial Joint
____Organ transplant
____Cancer
____Diabetes Type 1 or Type 2 (circle)
____Hepatitis
____ Stomach Problems/heartburn
____Acid Reflux or frequent vomiting (circle)
____ Sleep Apnea/Chronic Snoring
____ Epilepsy/Seizures
____ HIV positive or AIDS-ARC
____ STD (syphilis, gonorrhea, herpes, etc.)
____ TB, emphysema or lung disease (circle)
____ Arthritis, Type _____
____ Anemia
____ Osteoporosis/Osteopenia
____ Asthma
____ Rheumatic fever
____ Dry mouth
____ **Women only: Birth Control Pills**
____ **Women only: Presently pregnant or Nursing**

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DO YOU TAKE OR HAVE TAKEN:

___Recreational drugs
___Alcohol
___Tobacco in any form
___Phen Phen diet pills or any other diet pills
___Fosamax, Zometa, Boniva, Actonel (circle)

LIST ALL CURRENT MEDICATIONS/SUPPLEMENTS:

_____

_____

ALLERGIES: (Drugs, food, latex, metals, jewelry, acrylics, etc.):_____

_____

ALL PATIENTS: (circle)

Yes No Do you have or have you had any other diseases or medical problems **NOT** listed on this form?
If so, please explain: _____

Yes No Have you ever been told by a physician or dentist that you need to **pre-medicate** prior to any dental treatment?
If so, please explain:_____

TMJ History — Check all that apply

Have headaches _____
Chronic neck pain _____
Jaw popping, clicking or making noises _____
Pain or ringing in the ears _____
Jaw muscles feel tired, stiff or painful _____
Aware of clinching your teeth during the day _____
Been told you grind your teeth at night _____
Awaken with an awareness of your teeth or jaws _____
Trouble opening your mouth widely _____
Jaw locks open or closed _____
Bite is different, unstable, or uncomfortable _____
Sought treatment for a TMJ problem _____
Jaw affects your ability to chew _____

Sleep, Snoring and Apnea History

Become easily fatigued _____
If so what time of day?_____
Problems with insomnia _____
Do you sleep well? Yes____ No____
How many hours?_____
Do you dream? Yes____ No____
How often?_____
Trouble falling asleep or staying asleep _____
Snore or have been told you do _____
Wake up with a headache _____
Chronic sleepiness, fatigue, or weariness that cannot be explained _____
Fall asleep watching television or reading _____
Fallen asleep during the day against your will _____
Pull off the road while driving due to sleepiness _____
Been more irritable or short-tempered _____
Felt that your memory and/or intellect is impaired _____
Been told that you stop breathing while sleeping _____
About how many times per night do you wake up?_____
What time do you normally go to bed?_____, Get up in morning?_____
Of the hours in bed, how many are you asleep?_____
Please rate the quality of your sleep. Good_____Fair_____Poor____
Difficulty breathing through your nose _____
Present body weight_____ lbs. Height _____ft._____in.
Immediate family members been diagnosed or treated for sleep disorder _____
Been diagnosed or treated for sleep disorder _____
If so, when?_____
Had an evaluation at a sleep center _____
If so, Sleep Center Name:_____
Location:_____, Sleep study date:_____
If sought treatment for sleep disorder, did it help? Yes____No___

Notice of Privacy Practices Acknowledgement

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 can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved with that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Innovation Dental** to use and/or disclose certain protected health information (PHI) about me to carry out treatment, payment activities, and healthcare operations.

This authorization permits **Innovation Dental** to use and/or disclose the following individually identifiable health information about me:

All information in regards to dental care

Along with **Innovation Dental** information may be shared with:

_____	_____
Print Name	Relationship to patient
_____	_____
Print Name	Relationship to patient

I do not have to sign this authorization in order to receive treatment from **Innovation Dental**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the **Office Manager at Innovation Dental, 717 Insight Avenue, Suite 200, O'Fallon, IL 62269.**

_____	_____	_____
Signature	Relationship to patient	Date

Office use only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as stated below:

Date: _____ Initials: _____ Reason: _____

Our Financial & Commitment Policy

To create an understanding and partnership, No Surprises!

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the dental care we provide you and your family.

Patient's Role
As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement, it is important to remember your dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

Patient's estimated portion is to be paid in full at time of service for each appointment._____ (initial)

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA and DISCOVER. WE ALSO OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

Checks that are returned to our office from your financial institution are subject to a **$35.00** returned check fee. This fee covers the processing fees that are charged to our office.

Commitment to appointment – You must be present for all scheduled appointments. We do not allow multiple cancellations, missed appointments and constant appointment changes. We believe in mutual respect for each other's time. _____ (initial)

Regarding Insurance
We may accept assignment of insurance benefits; however, the balance is your responsibility. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Innovation Dental must take additional steps to collect my account, I will pay ALL cost of collections, including court cost and attorney's fees incurred by Innovation Dental.**

Thank you for reading our Financial Alliance. Please let us know if you have any questions or concerns.

I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

_____ _____
Signature of Patient or Responsible Party Date