Schreder Family Dental

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Dr. Kara L. Schreder, DMD.

4023 N. Illinois St.

Swansea, IL 62226

618-722-5300

 Chart #:

 FOR OFFICE USE ONLY

**Patient Information**

Patient Name: Date*:*

 Last, First MI (Preferred Name)

 Gender:  Family Status:

**SS#/SIN***:*  Birth Date: ***Age:***

Phone (Home):  (Work):  Ext: Best time to call:

Preferred appointment times:  Morning  Afternoon  Evening  Any Time M T W T F S

Address: **Email:**

 Street Apartment #

 City State/Province Zip/Postal Code

**Health Information**

Date of Last Dental Visit:  Reason for this visit:

**Have you ever had any of the following? Please check those that apply:**

|  |
| --- |
|  AIDS |
|  Allergies \_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_ |
|  Anemia  |
|  Arthritis Artificial Joints When: \_\_\_\_\_\_\_\_ What: \_\_\_\_\_\_\_\_ Asthma |
|  Blood Disease |
|  Cancer |
|  Diabetes Type I/II \_\_\_\_\_\_ |
|  Dizziness |
|  Eating Disorder Epilepsy |
|  Excessive Bleeding |
|  Fainting |
|  Glaucoma |
|  Growths |
|  Hay Fever |
|  Head Injuries |
|  Heart Disease/Heart Valves |
|  Heart Murmur |
|  Hepatitis |
|  High Blood Pressure |
|  Jaundice |
|  Kidney Disease |
|  Liver Disease Mental Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ MVP |
|  Nervous Disorders |
|  Pacemaker/ Defibrillator |
|  Pregnancy/ Nursing |
|  Due date: \_\_\_\_\_\_\_\_\_ |
|  Radiation Therapy  Reflux |
|  Respiratory Problems |
|  Rheumatic Fever |
|  Rheumatism |
|  Sinus Problems |
|  Stomach Problems |
|  Stroke |
|  Tuberculosis |
|  Tumors |
|  Ulcers |
|  Venereal Disease |
|  Codeine Allergy |
|  Penicillin Allergy |
| OTHER: |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Have you ever had any complications following dental treatment?  Yes  No

 If yes, please explain:

Are you required to take any antibiotics (Pre-Med) before each dental appointment?  Yes  No

 If yes, please explain:

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Do you have any health problems that need further clarification?  Yes  No

 If yes, please explain:

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Responsible Party Information**

The following is for:  the patient/patient's spouse  the person responsible for payment

Name:

  Male  Female  Married  Single  Child  Other

SS#/SIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_ Best time to call:

Address:

 Street Apartment #

 City State/Province Zip/Postal Code

**Employment Information**

The following is for:  the patient  the person responsible for payment

Employer Name: Occupation:

Address:

 Street City, State/Province Zip/Postal Code Phone

**Insurance Information**

**Primary**

Name of Insured: Is insured a patient?  Yes  No

 Last First

Insured's Birth Date:  ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

 Street City State/Province Zip/Postal Code

Insured's Employer Name:

 Address:

 Street City State /Province Zip/Postal Code

 Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

**Secondary**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is insured a patient?  Yes  No

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

 Street City State/Province Zip/Postal Code

Insured's Employer Name:

 Address:

 Street City State/Province Zip/Postal Code

 Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

# Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

  Dental Office  Website  Insurance  School  Work  Other

Name of person or office referring you to our practice:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

 Signature of patient, parent or guardian

 Date:

Signature of Dentist

Schreder Family Dental

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**ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES AND CONSENT FORM**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective February 17, 2015. We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice upon your request.

**Authorization of PHI Disclosure**: I give Schreder Family Dental permission to leave voice messages or messages with members of my household to confirm appointments, inquire about missed appointments or let me know of any recommended treatments when I am not available.

I also authorize the following person(s) to have access to the information covered under the Privacy Act regarding myself or my children:

Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children under 18 in my household this HIPPA form will cover:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Revocation of PHI Disclosure**: I understand that I may revoke this authorization by completing a new Acknowledgment of Receipt of Privacy Practices and Consent Form. I understand that I may not revoke this authorization during and insurance contestability period or with respect to disclosures that Schreder Family Dental may have already made in accordance with this authorization. I understand that when Schreder Family Dental discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

By signing below, I am acknowledging that I have received a copy of Schreder Family Dentals Notice of Privacy Practices. I am also giving Schreder Family Dental consent to disclose my protected health information to the person(s) listed above until such time a new Acknowledgement of Privacy Practices and Consent Form is completed by me. I understand and agree to the term of this authorization.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by Patient Representative, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schreder Family Dental

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**CONSENT FOR TREATMENT AND OFFICE POLICIES**

**PAYMENT FOR SERVICES**

As a condition of your treatment by this office, financial agreements must be made in advance. All co-payments are due at the time services are rendered.

After an account is overdue by 60 days it will be turned over to a collection agency for non-payment. Your will be responsible for any collection fees and/or court costs

Any emergency or after-hours dental services are subject to additional fees

**DENTAL INSURANCE POLICY**

Patients who carry dental insurance understand that payment for services is ultimately their responsibility. This office cannot render services on the assumption that our charges will be paid by an insurance company. As a courtesy to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. Any such collections will be credited to the patient’s account.

*KNOWING YOUR INSURANCE COVERAGE IS YOUR RESPONSIBILITY*. Insurance estimates are not a guarantee of coverage

**APPOINTMENT POLICY**

If you find it impossible to keep an appointment, for consideration of other patient’s needs, we ask for 24-hour notice. Appointments cancelled or missed without 24-hour notice will receive a missed appointment fee. These fees are $50 for the hygienist and $75 for the dentist.

After the third missed appointment without notice, you will be dismissed as a patient.

**X-RAYS AND CONSENT**

I authorize Dr. Schreder and her team to take any x-rays deemed necessary for the detection and diagnosis or oral diseases.

Your signature below fully authorizes our staff to perform any examinations and treatment that we consider dentally necessary. In addition, you give your full consent and agreement to all terms and conditions regarding payment of accounts explained here.

**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY/RELATONSHIP TO PATIENT**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by Patient Representative, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_