BATAVIA FAMILY DENTAL

PATIENT INFORMATION

Patient Name:____Birthdate:_________________
Last First, MI (Preferred Name)
Email Address:________________________________SSN:____________________Marital Status:____
Phone (Home):________________________(Cell):_____________________(Work)_________________
Address:____
Street Apt. #
____
City State Zip Code

HEALTH INFORMATION

Date of last dental visit:_____________
Since your last dental visit with OUR OFFICE, have you seen another dentist for any reason?__________
If yes, please explain:____

PLEASE CHECK ALL THAT APPLY:

__Anemia
__Arthritis
__Codeine Allergy
__Penicillin Allergy
__OTHER Allergies:
____
__Blood Disease
__Cancer
__Diabetes
__Dizziness
__Epilepsy
__Excessive Bleeding
__Fainting
__Glaucoma

__Hay Fever
__Head Injuries
__Heart Disease
__Heart Murmur
__Hepatitis
__High Blood Pressure
__HIV/AIDS
__Jaundice
__Kidney Disease
__Liver Disease
__Mental Disorders
__Nervous Disorders
__Pacemaker
__Pregnant
Due Date:_____________

__Rheumatism
__Stomach Problems
__Tobacco Products
__Tuberculosis
__ADD/ADHD
__Rheumatic Fever
__Ulcers
__Stroke
__Venereal Disease
__Sinus Problems
__Respiratory Problems
__Radiation
__Growths
__Thyroid Issues

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

____
____

Have you ever had any complications following dental treatment? _________YES _________NO
If yes, please explain:____
Have you been admitted to the hospital or needed emergency care during the past two years? If yes, please explain____
Are you under the care of a physician: ________YES _________NO
Name of Physician:____**Phone:**____________________

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.

X____**Date:**__________________________
Signature of patient, parent or guardian

Name:____**Date**:____________________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? __Friend __Another patient __Dental office
__Newspaper __Internet __School __ Work __Insurance Company __Yellow Pages __Other
Name of person or office referring you to our practice:____

INSURANCE INFORMATION

Insurance Company:__________________________________ Policy Holder's Name:______________________
Additional Information: ____

RESPONSIBLE PARTY INFORMATION

If patient is over 18: write "self" next to name only and skip the other areas.
If patient is under 18: all areas of this section must be completed.
Name (Please print):____ ___Male ___Female
Social Security #:_________________________ Birth Date:____________________
Phone (Home):__________________________ Cell:________________________ Work:____________________
Address:____
____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or with five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any branch of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, by cell or at my work to discuss matter related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X____ Date:_________________ Relationship to patient________________
Signature of patient, parent or guardian

Kenneth A. Korpan DDS
109 S. Batavia Avenue, Batavia, IL 60510
(630) 879-2011

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. IF YOU WISH TO SEE A FULL COPY OF ILLINOIS CURRENT PATIENT PRIVACY LAW(S), SEE THE FRONT DESK.

USES AND DISCLOSURES OF HEALTH INFORMATION. We use and disclose health and general information about you for treatment, payment, insurance and healthcare operation. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Insurance: We may release general information about you to obtain insurance and claim information.

Healthcare Operations: WE may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: You may give us written authorization to use your health information or to disclose it to any for any purpose. If you give us an authorization, you may revoke it in writing at any time.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

To Your Family and Friends: We may disclose your health information to a family member, friend or other person but only if you agree that we may do so. This can be a written authorization or verbal consent between the patient and the practice.

To ensure the privacy of others, we ask that you sign this agreement stating you understand these regulations and will abide by them. Due to the patient sign in sheets, location of operatory rooms and check out centers, we ask that you respect the privacy of others and their health information which consist of, but not limited to: treatment plans, appointment reminders, insurance inquiries, payment methods, etc.

Your signature below establishes that you have read and understand this agreement and will comply with office policies concerning patient privacy as well as your own. Your signature is written authorization to permit Batavia Family Dental Care and its entities the right to release personal and health information to other healthcare facilities, person(s) and organizations related to your treatment when deemed necessary.

____ ______________________________
Patient Signature (print patient's name if patient is a minor) Date

____ ______________________________
Guardian Signature (only if patient is a minor) Date

Please list the person(s) below to which you authorize Batavia Family Dental Staff to release information to and the relationship of that person to the patient. *(Please print)*

______________________________________ ______________________________________

Kenneth A. Korpan DDS
109 S. Batavia Avenue, Batavia, IL 60510
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FINANCIAL AGREEMENT

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All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that it is a COURTESY to our patients that we provide a breakdown of your insurance plan benefits and eligibility verification. Any insurance coverage information presented by our office/staff is only an ESTIMATION and never a guarantee of payment. Any balance owed after insurance is entirely patient responsibility.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

________ I have read the above conditions of treatment and payment and agree to their consent.
(initial)

Print Name of Patient:_______________________________________ Date:_________________________

Signature of Guarantor of Payment/Responsible Party:____

Relationship to patient:_____________________________