PATIENT REGISTRATION

ACCOUNT HOLDER INFORMATION

(Person Responsible For All Charges Incurred By Patients In The Account And Is The Policy Holder Of The Dental Insurance Plan Through Their Employer)

Name:_____ Date:_____

Birth Date:_____ Social Sec#:_____

Home Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Marital Status: Single / Married / Divorced / Widowed / Partnered

Employer:_____

Work Address: _____ City:_____ State:___ Zip:_____

Dental Insurance Company:_____ Group Number:_____

Please provide your dental insurance card and photo ID at check-in

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PATIENT INFORMATION FOR SPOUSE/CHILD/DEPENDENT/PARTNER

Name:_____ Birth Date:_____ Social Sec#:_____

Home Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship To You:_____

Home Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

CLOSEST RELATIVE NOT LIVING WITH YOU

Name:_____ Relationship To You:_____

Home Address: _____ City:_____ State:___ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Bruce B. Costagli D.D.S.

967 West Golf Road
Schaumburg, Illinois 60194
847.882.8989

www.BruceBCostagliDDS.com

Health Insurance Portability and Accountability Act (HIPPA) Compliance Agreement

I authorize Dr. Bruce Costagli DDS and his staff to share my medical, dental information with any doctor, pharmacy, insurance company, dental lab or any other entity as needed to ensure optimum dental care.

Patient Signature: _____ **Date** _____

Insurance Signature On File Compliance Agreement

I certify that the information given to me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Bruce B. Costagli DDS PC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage) as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the medical information to the insurer or agency shown and authorizes my doctor to act as my agent, as above.

Patient Signature: _____ **Date** _____

Please sign and date in both places.

HEALTH HISTORY OF _____

CIRCLE

Physician Name _____ Phone Number _____
Physician Address _____
Please list all prescription medicine that you are currently taking:
_____

1. Are you having pain or discomfort at this time? **YES NO**
2. Do you feel nervous about having dental treatment? **YES NO**
3. Have you ever had a bad experience in the dental office? **YES NO**
4. Have you been hospitalized during the past two years? **YES NO**
5. Have you been under medical care during the past two years? **YES NO**
6. Have you taken any medicine or drugs in the past 2 years? **YES NO**

7. Please check all the following which you currently/previously have had:

Heart Disease/Attack	Heart Failure	Heart Surgery	Emphysema
Artificial Heart Valve	Angina Pectoris	Heart Pacemaker	Heart Murmur
Congenital Heart Lesions	Blood Transfusion	Tuberculosis	Cough
Liver Disease	Hepatitis A	Hepatitis B	Hepatitis C
Yellow Jaundice	Kidney Trouble	Thyroid Disease	Anemia
High Blood Pressure	Stroke	Bruise Easily	Hemophilia
Rheumatic Fever	Scarlet Fever	Glaucoma	Ulcers
Venereal Disease	AIDS or HIV	Fever Blisters	Cold Sores
Allergies/Hives	Asthma	Hay Fever	Sinus Trouble
Difficulty Breathing	Artificial Joints	Cosmetic Surgery	Diabetes
Psychiatric Treatment	Drug Addiction	Dizzy Spells	Anxiety
Sickle Cell Disease	Epilepsy/Seizures	Jaw Joint Pain	Fainting
Cortisone Medicine	Arthritis	Rheumatism	Chemotherapy
Xray or Cobalt treatment			

8. Do you have any disease, condition, or medical problem not listed above?
   Please list:_____

9. **FOR WOMEN ONLY:** Are you pregnant? **YES NO** If yes, what month? ____
   Taking Birth Control Pills? **YES NO**

10. Please check all the following that you are allergic to or have had adverse reactions to in the past:

Aspirin	Nitrous Oxide	Valium	Novocaine Local
Darvon	Erythromycin	Scopolamine	Xylocaine Local
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Antibiotics	Sulfa Drugs

11. Are you allergic to any other medications or substances? Please list:
    _____

12. Do you smoke? **YES NO** Number of packs per day _____

Patient _____ Parent/Guardian _____ Date _____

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Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with the highest quality dental care. This statement is to inform you of our financial policy and is intended to facilitate excellent service to you while minimizing our administrative costs. You **must** read and sign this form prior to receiving any treatment at our office.

Regarding Indemnity Insurance

All charges incurred are your responsibility regardless of your insurance coverage. We must emphasize that our relationship is with you, the patient, and not with your insurance company. The insurance policy is a contract between you, your employer, and your insurance company. Please bring proof of insurance to each appointment and promptly notify us of any changes in your insurance. Our participation in your plan **may change;** therefore it is **your responsibility** to ask if we still participate in your plan before treatment is started.

Your co-payment and deductible is an estimate based on information received from your insurance company and must be **paid in full** at time of service. As a courtesy, we will assist you by processing your insurance claims. Once your insurance company has processed your claim, any difference will be due upon receipt of our statement. The balance is your responsibility whether your insurance pays or not. If ***for any reason*** we have not received your insurance carrier's payment **45 days** after the claim has been filed, the remaining balance will be due and payable by you. We will also ask for your assistance in following up with the insurance company for reimbursement.

Usual and Customary Rates

Because our practice is committed to providing the best treatment for our patients, we charge the usual and customary rates in our area. You are responsible regardless of your insurance company's arbitrary determination of the usual and customary rates, as well as for services we provide that are not covered under your insurance plan.

Minor Patients

Parents, guardians, or adults accompanying a minor are responsible for full payment. Non-emergency treatment will be denied for unaccompanied minors unless payment arrangements have been made in advance.

Missed appointments

Our policy is to charge for missed appointments at the rate of $50 per ½ hour of appointment time that you have asked us to reserve for you, unless the appointment has been cancelled at least 24 hours in advance.

Payments/Delinquencies

All monthly statements are due and payable upon receipt. We accept cash, checks, Visa, MasterCard, Discover and CareCredit. Patient with delinquent accounts are liable for all costs incurred for collection of past due balances, including collection agency fees, attorney fees, conciliation court fees, and all costs involved in litigation.

Interest

A finance charge of 18% annually (1.5% per month) will accrue on any unpaid balances after 60 days.

I have read and agree to the terms of this Financial Policy.

X _____ Date _____

Signature of Patient or Responsible Party