



MAGNER
FAMILY DENTAL

Welcome

Please complete and sign this confidential patient information form.
Thank you!

Child's Registration and History

CHILD'S INFORMATION

Today's Date: ___/___/___

Child's Name _____ Middle Initial ___ Last Name _____

Address _____

City: _____ State: _____ Zip: _____ email: _____

Parent's Address if different from above: _____

City: _____ State: _____ Zip: _____ email: _____

Date of Birth: ___/___/___

Home Phone: _____ Cell Phone: _____

DENTAL HEALTH HISTORY (CIRCLE ALL THAT APPLY)

Date of Last Visit: ___/___/___ Last Dental Cleaning: ___/___/___ Last X-rays: ___/___/___

| | | |
|--------------------------------|--------------------------------------|------------------------------|
| Mouth Discomfort | Bone Loss | Gums Bleed when Brushing |
| Grind or Clench Teeth | Orthodontic Treatment | Cold Sores or Fever Blisters |
| Negative Dental Experience | Sensitive Teeth (heat, cold, sweets) | Cold Sores or Fever Blisters |
| Prior Periodontal Treatment | Gum Abscess | Bruise Easily |
| Clicking, Popping, Pain in Jaw | Awaken with Sore Jaw | Other: |
| Fear of Dental Treatment | Mouth Odor or Bad Taste | |

Any unhappy dental experiences? _____

Any injuries to the mouth, teeth or head? _____

Any mouth habits (e.g. thumb sucking)? _____

Any unusual speech patterns? _____

Orthodontic appliances worn or recommended? _____

Does child brush daily? Yes No With assistance? Yes No How often? _____

Does child: Floss? Yes No Use mouth rinse? Yes No

What would you like us to know about this child's attitude towards dentistry?

MEDICAL HISTORY

Child's current Physician(s): _____ Office Phone: _____

Date of Last Visit: ___/___/___ May we contact Physician? Yes No

Does child have any medical condition that requires prophylactic antibiotics before dental visits? Yes No

List all medications the child is currently taking (include over-the-counter):

| | | | |
|--|--|--|--|
| | | | |
| | | | |

Is the child **allergic** or has had a reaction to the following medications? If so, circle which ones

| | | | |
|-------------------------|--------------|-------------|--------------|
| Acetaminophen (Tylenol) | Anesthetics | Aspirin | Carbocain |
| Codeine | Erythromycin | Ibuprofen | Keflex |
| Novocain | Penicillin | Sulfa Drugs | Tetracycline |
| Valium | Xylocaine | Other: | |

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child

Insured's Social Security No. _____ - _____ - _____ Insured's Date of Birth: ___/___/___

Insured's Occupation: _____ Insured's Employer: _____

Insurance Company: _____ ID # _____ Group # _____

Insurance Company's Address: _____

City: _____ State: ___ Zip: _____ Insurance Company's Phone No. _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child

Insured's Social Security No. _____ - _____ - _____ Insured's Date of Birth: ___/___/___

Insured's Occupation: _____ Insured's Employer: _____

Insurance Company: _____ ID # _____ Group # _____

Insurance Company's Address: _____

City: _____ State: ___ Zip: _____ Insurance Company's Phone No. _____

To the best of my knowledge, all of the preceding answers are true and correct. If at any point I experience any changes in my health or dedications, I will inform the doctor on or before my next appointment.

_____ ___/___/___

Signature

Date:

Relationship to child (circle one): Parent Legal Guardian Other: _____



MAGNER
FAMILY DENTAL

Financial Responsibility Agreement

Our practice is built on relationships and trust, an important part of which is that our patients fully understand their financial responsibilities. In order to continue providing superior care and service, we ask that you please agree to the following office financial policy.

INSURANCE

Dental insurance is designed to help offset the cost of dental care. Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, whatever the reason.

On your behalf, we can contact your insurance company to help determine your level of benefits. Insurance estimates will assist you in determining our approximate out-of-pocket expenses. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.

Your insurance policy is a contract between your employer and your employer's insurance company. We are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.

PAYMENT POLICIES:

As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our patients for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. We will discuss financial options with you before rendering treatment.

By signing below, you are agreeing to all of the terms contained in this Financial Responsibility Agreement, including the following:

- Payment is due in full at time of service unless prior written financial arrangements have been made.
- There is a \$35 service charge on all returned checks.
- We reserve the right to charge a missed appointment fee for no-shows or cancellations with less than 24-hour notice.

I understand and agree that any account balance not paid within 90 days will be subject to collection activity. I understand that Magner Family Dental may retain the services of a collection agency and/or an attorney to assist with the collection of any outstanding balance.

Patient further agrees to pay any additional collection agency fees, court costs and reasonable attorney fees should your account be placed with our outside collection agency and/or law firm in order to collect the outstanding balance owed under this agreement. The collection agency fee will be thirty-five (35) percent and will be based on the percentage of the balance of the debt being turned over to the collection agency at that time.

Additionally, patient agrees to pay simple interest at the rate of 1½% per month on the outstanding principal balance of the patients account starting from the last date of service, last payment date or final statement date, whichever is most current.

I/we understand that pursuant to the Illinois Family Expense Act, **both parents**, are equally responsible for any and all debts incurred as a result of medical treatment provided to a minor. This law take priority over any divorce decree or agreement as to which parent has custody or who has insurance or how any medical bills with respect to a minor are to be paid.

If the phone number(s) patient is providing included cellular telephone number(s), patient consents to receiving auto dialed or prerecorded message calls from an outside collection agency and/or law firm who may call when attempting to collect on any past due accounts our office has placed with them.

I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances due to Magner Family Dental for myself and any other family members listed on the same account.

Print Patient Name: _____

Guarantor Signature: _____ Date: ____/____/____

Patrick R. Magner, DMD

1220 Meadow Road, Suite 206, Northbrook, IL 60062 847.272.1588



MAGNER
FAMILY DENTAL

Payment Options

Magner Family Dental offers several convenient payment options to help make your dental care affordable.

- We accept cash, check, Visa, MasterCard, American Express, and Discover at time of service.
- We offer 3 months interest free financing through our office for services over \$750. Your fee will be divided into three equal payments with the first payment to be made at the onset of treatment.
- We will accept the assignment (payment) in insurance benefits in some instances provided that your coverage has been verified and we have current credit card information on file to charge any remaining balance not paid by your insurance company. We may request payment of your estimated out-of-pocket expense at the time of service.

At the onset of your treatment, we will provide you with an estimate of your treatment costs. Should the need for additional treatment arise during the course of the original treatment plan, the estimated fees may change. Be assured that we will notify you of any fee changes and obtain your approval prior to proceeding with treatment. Please feel free to discuss any questions you may have regarding the payment options described above with our Financial Coordinators. We thank you for entrusting us with your dental care needs.

Signature: _____ Date: ___/___/___

Patrick R. Magner, DMD
1220 Meadow Road, Suite 206, Northbrook, IL 60062 847.272.1588



MAGNER
FAMILY DENTAL

HIPAA Compliance

Patient Consent to Receive Mail
and/or Telephone Messages.

Patient Name (please print) Last: _____ First: _____

Relationship to Patient (please circle one):

Self Spouse Parent Child Legal Guardian Other: _____

1. Do we have your permission to send appointment reminders, financial, and dental information to your:
 - a. Home Yes No
 - b. Cell Phone Yes No
 - c. Work Phone Yes No
 - d. Email Yes No

2. I hereby give permission to share any information concerning me with the person(s) named below:

a. Name: _____

b. Name: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information.

We reserve the right to change our privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by referring to our website: www.magnerdental.com.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice.

Signature: _____ Date: ____/____/____

Patrick R. Magner, DMD

1220 Meadow Road, Suite 206, Northbrook, IL 60062 847.272.1588



MAGNER
FAMILY DENTAL

Credit Card on File Agreement

Magner Family Dental has a Credit Card on File policy to streamline our billing and to provide a seamless, convenient way for you to pay for your services. All patients are asked to keep a Credit Card on File with us. Your payment information will be stored securely for future transactions. Office personnel will not have access to your full credit card number; only the last 4 digits of your card show in our system.

If you have dental insurance: For most insurance plans, you are responsible for paying the full balance to Magner Family Dental at the time of service. Once your insurance company processes the claim, they will reimburse you the amount they cover.

For some insurance plans, you will pay after we receive the insurance payment. Once your insurance has processed your claim, they will send an Explanation of Benefits (EOB) to you by mail or make it available through an online portal. Our office will also receive a copy. The EOB will show what your patient responsibility is. Should there be a patient portion due, we will use the Credit Card on File to satisfy the account balance. If the amount due is over \$400, you will receive a courtesy call or text prior to the charge being placed.

If you do not have dental insurance: Payment is due at time of service. We can use the card on file or take payment with cash or check.

I **decline** to keep a Card on File and agree to pay my **balance in full** at time of service by cash, check, or credit card. If I have insurance, I will then be reimbursed the amount my insurance covers, if any.

I authorize Magner Family Dental to keep my credit card information securely on-file. I authorize Magner Family Dental to charge my credit card for any outstanding balances equal to or less than \$400. If the amount being charged is over \$400, I will receive a courtesy call or text prior to the charge being placed.

I **authorize** my Card on File to be used for my care and that of the following individuals:

Printed Name: _____

Signature: _____

Email for receipts: _____

Cell phone number for receipts: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PURSUANT TO FEDERAL REGULATIONS.

PLEASE REVIEW IT CAREFULLY.

At **Magner Family Dental**, we understand that information about you and your health is personal. We are committed to protecting your health care information. We create a record of the care and services you receive directly from our medical staff. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices (“Notice”) applies to all of the records of your care generated by our office.

This Notice will tell you about the ways in which our office may use and disclose your protected health information (“PHI”). This Notice also describes your rights and certain obligations our office has regarding the use and disclosure of PHI.

REGULATORY REQUIREMENTS. Our office is required by law to maintain the privacy of your PHI, to provide individuals with notice of our office’s legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect. Information disclosed pursuant to this Notice may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

YOUR RIGHTS. You have the following rights regarding your PHI:

Restrictions. You may request that our office restrict the use and disclosure of your PHI. To request restrictions, you must make your request in writing to our Privacy Officer using the applicable form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications. You have the right to request that communications of PHI to you from our office be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing using our form and sent to the Privacy Officer. We will accommodate your reasonable requests.

Inspect and Copy. Generally, you have the right to inspect and copy your PHI that our office maintains, provided that you make your request in writing to our Privacy Officer. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If our office does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

Amendment. If you believe that your PHI maintained by our office is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI. We can deny your request if your request relates to PHI: (i) not created by our office; (ii) not part of the records our office maintains; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and our office’s denial attached; and (iii) complain about the denial.

Accounting of Disclosures. You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). This right includes an accounting of disclosures made for treatment, payment, and healthcare operations through an electronic health record during the three years prior to your request. The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) for our office’s patient list;

(iv) for national security or intelligence purposes; or (v) to law enforcement officials. You should submit any such request to our Privacy Officer. We will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of the costs of providing the list.

Right to Copy of Notice. You have the right to receive a paper copy of this notice upon request. To obtain a paper copy of this notice, please contact the Privacy Officer at:

Magner Family Dental
ATTN: Dr. Patrick Magner
1220 Meadow Rd., Suite 206, Northbrook, IL 60062
847-272-1588
Fax: 847-272-0581
info@magnerdental.com

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. Our office may use or disclose your PHI for the purposes described below **without obtaining written authorization from you.** In addition, our office and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement. We may also disclose your PHI to certain contractors or other business associates that provide service to our office; these “Business Associates” will be subject to HIPAA and are required to comply with the same restrictions and prohibitions that apply to us.

For Treatment. Our office may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider.

For Payment. Our office may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, we may need to give PHI to your health plan in order to be reimbursed for the services provided to you. We may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. We may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. Our office may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, credentialing and peer review activities, and health care fraud and

abuse detection or compliance, and management and administration. We may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure our office is complying with all applicable laws, and to help us continue to provide quality health care to its patients.

As Required by Law and Law Enforcement. Our office may use or disclose PHI when required to do so by applicable laws and when ordered to do so in a judicial or administrative proceeding. We may also use or disclose PHI upon a properly documented and limited request from law enforcement agencies.

Special Protections for Substance Use Disorder Records: If our office receive or maintain records protected by federal law relating to substance use disorder (42 CFR Part 2), we will not use or disclose such records in any civil, criminal, administrative, or legislative proceedings against you without your specific written consent or a court order that meets the requirements of the law.

For Public Health Activities and Public Health Risks. Our office may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. Our office may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. Our office may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Research. Under certain circumstances, we may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition.

To Avoid a Serious Threat to Health or Safety. Our office may use and disclose PHI, to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. Our office may use and disclose PHI of military personnel and veterans under certain circumstances. We may also disclose PHI to authorized federal officials for intelligence, counter intelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Disclosures to You or for HIPAA Compliance Investigations. Our office may disclose your PHI to you or to your personal representative, and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. Our office must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate our compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

Patient List; Marketing. Unless you object, our office may use some of your PHI to maintain a list of patients it has served. This information may include your name, treatment facility, and the services we provided to you. This patient list and the information on it may be used for marketing purposes. If we intend to use or disclose

your substance use disorder records for fundraising or marketing purposes, our office will first provide you with a clear and conspicuous opportunity to elect not to receive any such communications.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, our office may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care.

OTHER USES AND DISCLOSURES. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization; you have the right to revoke your authorization in writing. If you revoke your authorization, our office will no longer use or disclose PHI about you for the reasons covered in your written authorization. Please understand that our office is unable to recover any disclosures already made with your authorization, and that we are required to retain records of the care provided to you.

RIGHT TO FILE A COMPLAINT. At our office, we value the relationships we develop with our patients, our patients' privacy, and the trust our patients' have in us. As such, we make every effort to remedy any issues or concerns you may have. You may submit any complaint regarding your privacy rights to:

Magner Family Dental
ATTN: Dr. Patrick Magner
1220 Meadow Rd., Suite 206, Northbrook, IL 60062
847-272-1588
Fax: 847-272-0581
info@magnerdental.com

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office for Civil Rights. You will not be penalized for filing a complaint. You may contact the Office for Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
T: (800) 368-1019
F: (312) 886-1807

The process for filing a complaint regarding the unauthorized use or disclosure of records protected by 42 CFR Part 2 (Substance Use Disorder records) is the same as the process described above for any other privacy complaint.

PLEASE CONTACT THE PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OF PRIVACY PRACTICES OR YOUR PRIVACY RIGHTS.

Acknowledgement of Receipt Notice of Privacy Practices Magner Family Dental

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____ Date: _____

Signature: _____

Right to Revoke:

_____ **SIGN THIS PORTION AT A LATER TIME/DATE** _____

I have the right at any time to revoke this Acknowledgement for any reason. I have the right to sign this portion **at a later time/date** of my choice to revoke my Acknowledgment.

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify): _____