Advocate Illinois Masonic Medical Center
Dentistry Department

PATIENT REGISTRATION FORM

NAME
NOMBRE

LAST/APELLIDO | FIRST/NOMBRE | M.I./INICIAL

ADDRESS
DIRECCION

STREET AND NUMBER/ CALLE Y NUMERO

CITY/CIUDAD | STATE / ESTADO | ZIP CODE
ZONA POSTAL

PHONE NUMBER/
NUMERO
TELEFONO

A.C. HOME/CASA | A.C. BUSINESS/TRABAJO | EXT.
EXTENCION

BIRTH DATE
FECHA
NACIMIENTO

MARITAL STATUS
ESTADO CIVIL

S S | M C | D D | W V | SEP SEP

SEX
SEXO

M | F

EMPLOYER INFORMATION – Guarantor/Guardian:

Employer/Empleador_____

Address/Direccion_____

City/Ciudad | State/Estado | Zip Code/Zona Postal

Position or Title
Posicion o Titulo

Telephone #
Numero de Telefono

Social Security No. _____
Numero Seguro Social

Spouse/Esposa:

Employer/Empleador: _____

Address /Direccion_____

City/Ciudad | State/Estado | Zip Code/Zona Postal

Position or Title
Posicion o Titulo

Telephone No.
Numero de Telefono

Social Security No. _____
Numero Seguro Social

METHOD OF PAYMENT/ MODO DE PAGO (circle one/circule uno) INSURANCE/SEGURO CASH/EFECTIVO VISA/MASTER CARD

INSURANCE/SEGURO_____ Group No./ Grupo y Numero_____
Patient's carrier name/Nombre del Paciente

_____ Group No/ Grupo No._____
Spouse or Parent's carrier name/Esposa o Padre

FAMILY INFORMATION: Please list names of other family members who are patients here:
INFORMACION FAMILIAR: Por favor anote sus familiares que son pacientes aqui:

LAST/APELLIDO | FIRST/NOMBRE | RELATIONSHIP/RELACION | DENTIST/DENTISTA

I, the undersigned understand that I am responsible for payment for any services rendered by the staff of this dental office that is not covered by my dental insurance or any other third party payor.
Yo, el que firma entiendo soy responsable por el pago de cualquier servicio que reciba en esta oficina si este no fuera cubierto por mi seguro

Guarantor's Signature/Firma del Guardian_____ Date/Fecha _____

Patient's Signature/ Firma del Paciente_____ Date/Fecha_____

WHO REFERRED YOU TO THE DEPARTMENT OF DENTISTRY? _____
¿Quien lo refirio al Departamento Dental?

Advocate Illinois Masonic Medical Center
Department of Dentistry/ Departamento De Odontologia

C

Medical and Dental History/Historia Clinica Y Dental

Name/Nombre y appelido _____

Birthdate/Fecha de nacimiento _____ Date/Fecha _____

This information is requested of you to enable the dentist to give your child the most comprehensive treatment possible. The answers will remain part of your child's permanent dental record and will be kept strictly confidential. If you are unable to answer a question about your child's health history, or if you are unsure of the answer, please ask your child's dentist. Thank you

La información que solicitamos le permitirá a su dentista ofrecerie a su hijo(a) el tratamiento más completo posible. Sus respuestas formarán parte del registro dental permanente y confidencial de su hijo(a). Si no puede contestar alguna pregunta, o no está seguro(a) de la respuesta, consulte a su dentista. Muchas gracias por su cooperación.

1. Is your child presently undergoing any medical treatment? ¿Está actualmente su hijo(a) bajo tratamiento médico?

   _____ No _____ Yes/Si _____

2. Date of your child's last medical examination/Fecha del último examen médico de su hijo(a): _____

3. Family physician's name/ Nombre de su médico familiar: _____
   Telephone #/Teléfono _____

4. Has your child ever been hospitalized? ¿Ha sido hospitalizado(a) su hijo(a) alguna vez?
   ____ No ____ Yes/Si _____
   _____

5. List all of your child's surgeries (give type of surgery and date)/ Indique todas las operaciones que haya tenido su hijo(a). (Escriba el tipo de operación y la fecha).
   _____
   _____

6. Check any of the following conditions which your child may have had, or presently has:
   Indique si su hijo(a) padece o ha padecido de alguno de los siguientes problemas:

a.	Congenital heart defects/Defectos congénitos del corazón	___ No ___ Yes/Si
b.	Heart murmur/Sopio cardíaco	___ No ___ Yes/Si
c.	Rheumatic fever or scarlet fever/ Fiebre reumática o escarlatina	___ No ___ Yes/Si
d.	Respiratory problems or asthma/Problemas respiratorios o asma	___ No ___ Yes/Si
e.	Hay fever/fiebre de heno	___ No ___ Yes/Si
f.	Kidney disease/Enfermedades de los riñones	___ No ___ Yes/Si
g.	Urinary tract infection/Enfermedades del sistema urinario	___ No ___ Yes/Si
h.	Livery disease/Enfermedades del higado	___ No ___ Yes/Si
i.	Bleeding problems/Problemas de sangrado	___ No ___ Yes/Si
j.	Epilepsy/convulsions – Epilepsia/convulsiones	___ No ___ Yes/Si
k.	Thyroid disease/Enfermedades de la tiroides	___ No ___ Yes/Si
l.	Steroid/cortisone use – Uso de cortisona o esteroides	___ No ___ Yes/Si
m.	Diabetes	___ No ___ Yes/Si
n.	Contagious diseases (i.e., mumps, measles, hepatitis, etc.) Enfermedades contagiosas (p.ej. paperas, sarampión, hepatitis, etc)	___ No ___ Yes/Si
o.	Psychiatric disorders/Problemas psiquiátricos	___ No ___ Yes/Si
p.	Blood transfusions/Transfusiones de sangre	___ No ___ Yes/Si
q.	Drug and/or alcohol abuse/Abuso de drogas o del alcohol	___ No ___ Yes/Si

7. Is your child pregnant at this time? ¿Esta embarazada actualmente su hija?

   _____ No _____ Yes/Si _____ Trimester/Trimestre _____

8. Is your child taking any medications?/ ¿Está tomando su hijo(a) algún medicamento?

_____ No _____ Yes/Si _____

9. Is your child allergic to any medications? ¿Es su hijo(a) alérgico(a) a algún medicamento?

_____ No _____ Yes/Si _____

_____

10. Is there any other medical conditions about which your child's dentist should know? / ¿Tiene su hijo(a) algún problema médico que el dentista deberia conocer?

_____ No _____ Yes/Si _____

_____

Dental History – Historia Dental

1. Date of your child's last dental visit/Fecha de la última visita de su hijo(a) al dentista _____
   Reason/ Motivo de la vista _____

2. Are there any concerns or complaints about your child's teeth and/or gums at this time?
   ¿Tiene su hijo(a) algún problema con los dientes o con las encías?
   _____ No _____ Yes/Si _____

3. Has your child ever had problems associated with dental anesthetics?
   ¿Tiene o ha tenido su hijo(a) problemas con anestésicos dentales?
   _____ No _____ Yes/Si _____

4. Does your child suffer from/¿Sufre su hijo(a) de alguno de estos problemas?
   a. cold sores/herpes o ulceración labial ___ No ___ Yes/Si
   b. popping or clicking noises in joint when chewing
      ruidos extraños en la mandíbula al masticar o al bostezar ___ No ___ Yes/Si
   c. lumps in mouth/nódulos o ganglios en la boca ___ No ___ Yes/Si
   d. bleeding gums/enciás que sangran o que se han retraído ___ No ___ Yes/Si
   e. grinding or clenching of the teeth/rechinar los dientes ___ No ___ Yes/Si
   f. discolored teeth/dientes descoloridos ___ No ___ Yes/Si
   g. crowded teeth/dientes encimados ___ No ___ Yes/Si
   h. thumb sucking/chuparse el dedo ___ No ___ Yes/Si

5. Is your child still on the bottle? ¿Toma su hijo(a) biberón? ___ No ___ Yes/Si

6. Is your child apprehensive about this dental appointment?/
   ¿Le tiene su hijo(a) miedo al dentista? ___ No ___ Yes/Si

7. Has your child ever had an unfavorable dental experience?
   ¿Ha tendio su hijo(a) alguna experiencia dental desfavorable? ___ No ___ Yes/Si

_____

_____
Parent or guardian signature/Firma del padre o tutor

_____
Relationship to patient/Relacion con el paciente

_____
Date/Fecha

_____
Dentist Signature/Firma del dentista

Revised 8-23-01

Patient Name: _____ Date: _____

C

History of Latex Allergy

Please check all that apply:

		Yes	No	Unsure
1.	Do you have (or think you have) an allergy to latex or rubber?	☐	☐	☐
2.	Have you every had an allergic reaction to latex that required a visit to an Emergency Room or the doctor?	☐	☐	☐
3.	Do your hands "break out" when you put on rubber gloves or after you have worn them for some time?	☐	☐	☐
4.	Do your lips swell or tingle when you blow up balloons?	☐	☐	☐
5.	Have you experienced swelling, itching or discomfort after using a condom?	☐	☐	☐
6.	Have you had unusual swelling or discomfort after a physical exam or an invasive procedure where a health care provider wore gloves?	☐	☐	☐
7.	Do your allergies (swelling, itching, hives, runny nose, wheezing) or asthma get worse after contact with latex or a rubber product at home, at the dentist, while working or when you are in a hospital or other place where rubber gloves are worn?	☐	☐	☐
8.	Have you ever had an allergic reaction (airway swelling, difficulty breathing, blood pressure drop, rapid heart rate) during a dental procedure, surgery or childbirth?	☐	☐	☐
9.	Do you have any allergies to kiwis, bananas, avocado, or chestnuts?	☐	☐	☐
	Other allergies, *please specify?* _____			
10.	How many operations have you had in the past counting dental surgeries and OB-Gyne procedures? _____	☐	☐	☐

Comments:

Signature of person filling out this form: _____

Advocate Health Care

Patient Name: _____

MRN/DOB: _____

HEALTH CARE CONSENT

1. TO TREAT. I, for myself (or the patient named below) hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness in an Advocate emergency department, hospital or for a course of outpatient treatment in the judgment of my physician(s), to be performed by the hospital, nurses, other health care providers, and physicians. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such student involvement in my care.

2. RESPONSIBILITY FOR PAYMENT. In consideration of services to be rendered at the hospital, the undersigned agrees, as patient or guarantor for patient, to pay the hospital for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. I accept responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this hospital treatment is, to the best of my knowledge, complete and accurate. I understand that if I am having difficulty in meeting my payment responsibilities to the hospital, financial counseling services are available upon request, including charity care consideration.

3. ASSIGNMENT OF BENEFITS. In consideration of services rendered at the hospital, I hereby assign and authorize direct payment to the hospital and the treating physicians, any insurance, health plan or third party payor benefits otherwise payable to me or on my behalf for this hospitalization, emergency room or outpatient services.

4. MEDICARE PAYMENT AND ASSIGNMENT OF BENEFITS (if applicable). I request that payment of authorized Medicare benefits be made on my behalf for hospital and physician services furnished to me at the hospital and I assign such benefits to the hospital and physicians providing same. I certify that the information given by me in applying for such benefits is correct and that I have completed a Medicare questionnaire. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorize the Social Security Administration to release information about my entitlement to benefits to hospital and physicians providing services to me.

5. RELEASE OF MEDICAL INFORMATION FOR PAYMENT.
   A. General Release for Payment. I hereby authorize the hospital and any physician or other healthcare provider who may treat me to release any and all pertinent information contained in my medical records, including HIV, to third party payors responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.
   B. By initialing in the space below, I do not consent to the release of medical information concerning HIV diagnosis or treatment, if any, to third party payors and understand that I am personally responsible for payment for services.
      HIV ____

6. DURATION AND REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING. This authorization to release information related to payment expires upon satisfactory payment of the bill. This authorization (or the refusal under paragraph 5 B), may be revoked at any time by written notice to the Health Information Management/Medical Records Department (with no effect on prior disclosures). If I revoke this authorization prior to satisfactory payment, I understand and accept that I am personally responsible for payment of all outstanding charges.

7. PERSONAL BELONGINGS. I assume full responsibility for all items of personal property, including but not limited to, eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I understand that valuables may be kept in the hospital safe upon my request and hereby release the hospital of responsibility and liability for those valuables and items of personal property which are not deposited with the hospital for safekeeping.

8. INDEPENDENT PHYSICIAN SERVICES. I acknowledge and fully understand that some or all of the physicians who provide medical services to me at the hospital are not employees or agents of the hospital, but rather independent practitioners on the hospital medical staff who are permitted to use the hospital facilities to render medical care and treatment. Non-employed physicians may include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. My decision to seek medical care at the hospital is not based upon any understanding, representation, advertisement, media campaign, inference, implication or reliance that the physicians who are or will be treating me are employees or agents of the hospital.

I acknowledge that the hospital bill does not include most physician services and I understand that I will receive separate physician bills.
I have read and understand the above terms of treatment and confirm that I am the patient or am authorized to sign on the patient's behalf.

Patient Name: _____ Date: _____

Patient Signature: _____ Witness Signature: _____
(or Parent/Legal Guardian, Personal Representative)
If not signed by patient.

Advocate Illinois Masonic Medical Center

C

ADVOCATE HEALTH CARE
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. PLEASE REVIEW IT CAREFULLY.

I have received the attached Advocate Health Care Notice of Privacy Practices.

Signature of Patient _____ Signature Date _____

Print Name _____ Date of Birth of the Patient or Medical Record Number _____

Signature of Parent/Legal Guardian/Legal Representative _____ Relationship to Patient _____

Witness (if not signed by patient) _____ Signature Date _____

This Notice applies to the following Advocate Health Care Sites:

Hospitals and Medical Staffs

Advocate Bethany Hospital
Advocate Christ Medical Center and Hope Children's Hospital
Advocate Good Samaritan Hospital
Advocate Good Shepherd Hospital
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital and
Lutheran General Children's Hospital
Advocate South Suburban Hospital
Advocate Trinity Hospital

Medical Groups

Advocate Health Centers
Advocate Medical Group
Dreyer Clinic, Inc

Others

Advocate Home Care Products, Inc.
Advocate Home Health Services
Advocate Hospice
ACL (Lab Venture)
Family Care Network
Fitness and Wellness Centers
High Technology, Inc.
Occupational Health Centers
Any other health care facility or physician practice currently owned by Advocate

Disclaimer

This Advocate Health Care ("Advocate") site has decided to use a joint Notice of Privacy Practice and a joint Acknowledgement Form with independent physicians who are not employed by Advocate. The use of these joint forms rather than the use of separate notices and forms is being done only for the patient's convenience and to improve the access to patient health information by the patient's physician.

Although this notice does address the sites listed on the first page of the notice, any independent physicians are and remain independent contractors and are not agents, servants or employees of Advocate and are solely responsible for their judgment and (medical) conduct in treating or providing professional services to the patient and for their compliance with state and federal privacy laws. Nothing in this privacy notice is meant to imply, infer or create any agency or employment relationship between any independent physicians and Advocate, either actual or implied; (nor is it intended to create reliance on the part of the patient); nor is this privacy notice intended to alter or limit any other consents for treatment or procedures the patient may sign during the time the patient is provided care at this facility.

This notice is effective August 2, 2004.

APPOINTMENT CANCELLATION AND PAYMENT POLICY
ADVOCATE, ILLINOIS MASONIC MEDICAL CENTER
DEPARTMENT OF DENTISTRY, DENTAL CENTER

Welcome to our dental practice. We appreciate the opportunity to serve you as a patient in our Dental Center. Please be assured that our dentists and staff will do everything possible to making your experience positive.

In order to better manage your dental treatment, we wanted to familiarize you with our policies regarding appointment scheduling/cancellation and payment for services. We ask your cooperation in respecting these policies to keep billing costs down and valuable appointment time available to all our patients.

APPOINTMENT CANCELLATION POLICY:

All appointments are scheduled in advance with our receptionist. Our dental providers see only one patient per hour. This time was set aside for your personal dental needs. If you are unable to keep an appointment, we ask that you give our office at least 24 hours notice.

THE FOLLOWING COURSE OF ACTION WILL BE TAKEN FOR APPOINTMENTS WHICH ARE FAILED OR CANCELLED WITH LESS THAN 24 HOURS NOTICE:

1ST Occurrence:
The Appointment Cancellation Policy is explained to the patient.
The patient will be given another appointment.

2nd Occurrence:
- If patient fails to give 24 hours notice of cancellation or fails the appointment, a $30 fee will be charged.
- Patient will be given another appointment only after $30 fee has been paid.

3rd Occurrence:
- Patient will be given a termination notice from the practice and must find another dental provider within 30 days of notification.

PAYMENT POLICY:

Payment for all services, including deductibles and co-payments, is due at the time of service, unless, other arrangements have been made with our office.

PLEASE NOTE: in the event that your insurance company has not paid their expected portion within 60 days, the balance will become your responsibility. In addition, if your insurance pays but leaves a balance, that balance becomes your responsibility.

THE FOLLOWING COURSE OF ACTION WILL BE TAKEN FOR UNPAID DEDUCTIBLES AND COPAYMENTS.

1ST Occurrence:
- The payment policy is explained to the patient.
- The patient will be seen, as scheduled.
- The patient must pay the outstanding balance due before next visit.

2nd Occurrence (and all subsequent occurrences):
- The appointment will be rescheduled for a later date when the patient is prepared to pay the expected deductible or co-payment.

I have read and understand the Department of Dentistry's Appointment Cancellation and Payment Policies.

Patient Signature: _____ Date: _____

THE DENTISTS AND STAFF OF THE DEPARTMENT OF DENTISTRY,
THANK YOU, IN ADVANCE FOR YOUR COOPERATION.