Advocate Illinois Masonic Medical Center
836 West Wellington Avenue || Chicago, IL 60657 || T 773.975.1600 || advocatehealth.com

Special Patient Dentistry Care
811 West Wellington
Chicago, Illinois 60657
T (773) 871-2188
F (773) 871-6353

Changes to Adult Special Patient Dental Program

As of January 1, 2021 There will be a charge of $51.00 for all failed appointments.

A failed appointment is defined as not giving 48 hour notification, and if appropriate forms are not complete, and consents are not signed by legal guardian. The one exception to this policy is if the patient is ill and in these instances, a Doctor's note will be required before the failed appointment fee will be removed. This amounts needs to be paid before given another appointment. Failed IV Sedation appointments will be charged $316.00 **{If a patient ate the day of appointment is considered a Failed IV sedation appointment}.**

1. **IV SEDATION $613.00**
2. **TREATMENT PLAN FOR FUTURE APPOINTMENTS OUTLINED EXPECTED FEES**
3. **COPAY WILL BE DUE AT THE TIME OF SERVICE**
4. **DENTAL CLEANING AND EXAM $174.00**

These changes have become necessary due to the rising cost of operating the program and the increased demand for these appointments.

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 S M D W SEP **SEX** M F
ESTADO CIVIL S C D V SEP SEXO

EMPLOYER INFORMATION – Guarantor/Guardian:
Employer/Empleador_____
Address/Direccion_____
_____ _____ _____
City/Ciudad State/Estado Zip Code/Zona Postal
_____ _____
Position or Title Telephone #
Posicion o Titulo 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 Telephone No.
Posicion o Titulo 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?

TO BE FILLED OUT BY PARENT/LEGAL GUARDIAN OR CARETAKER

PATIENT'S NAME_____ DATE_____ RACE_____ SEX: M____F____

PATIENT LIVES AT: HOME_____FACILITY_____ LANGUAGE SPOKEN_____

PATIENT'S ADDRESS_____ WEIGHT_____ HEIGHT_____

_____ GUARDIAN'S NAME_____

Telephone #_____ GUARDIAN'S ADDRESS_____

FATHER'S NAME_____ _____

MOTHER'S NAME_____ _____

MOTHER'S MAIDEN NAME_____ TELEPHONE # HOME_____

PATIENT'S DATE OF BIRTH: MONTH___DAY___YEAR___ TELEPHONE # WORK_____

EDUCATIONAL LEVEL_____ DATE OF GUARDIANSHIP APPOINTMENT_____

EMPLOYMENT STATUS_____ TYPE OF GUARDIANSHIP_____

SOCIAL SECURITY #_____ GRANT_____

MARITAL STATUS: single__married__divorced__widowed__ PHYSICAL COORDINATION: (PLEASE CHECK ONE)

CITIZEN OF: USA___OTHER_____ SITTING: NONE__ POOR__ FAIR__ GOOD__

DEVELOPMENTAL DIAGNOSIS_____ STANDING: NONE__ POOR__ FAIR__ GOOD__

AGE OF ONSET: Birth_____ Other age_____ WALKING: NONE__ POOR__ FAIR__ GOOD__

STATE OF HEALTH: GOOD___FAIR___POOR_____ BALANCE: NONE__ POOR__ FAIR__ GOOD__

DATE OF LAST MEDICAL EXAM_____ GRASPING: NONE__ POOR__ FAIR__ GOOD__

PHYSICIANS NAME_____ SPEECH: NONE__ POOR__ FAIR__ GOOD__

TELEPHONE #_____ VISION: NONE__ POOR__ FAIR__ GOOD__

HAS PATIENT EVER BEEN HOSPITALIZED: YES___NO___ HEARING: NONE__ POOR__ FAIR__ GOOD__

WHY_____ IS PATIENT IN WHEEL CHAIR YES___ NO___

WHERE_____ PATIENTS ABILITIES: (PLEASE CHECK ONE)

HISTORY OF SEIZURES: YES___NO___ FEEDS SELF YES___NO___WITH HELP____

TYPE OF SEIZURES:_____ DRESSES SELF: YES___NO___WITH HELP___

PRESENTLY CONTROLLED: YES___NO___ TOILET TRAINED YES___NO___WITH HELP___

ALLERGIES:(if none please state none)_____ MEDICATION IN USE: (if none, please state none)

_____ NAME DOSAGE TIMES PER DAY

_____ _____

_____ _____

All information must be filled out. NA is not an acceptable answer.

HAS PATIENT EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS? (please check which ones)

PATIENT'S NAME_____ DATE_____

YES___NO___ HEART DISEASE

YES___NO___ HEART ATTACK

YES___NO___ PAIN OR PRESSURE IN THE CHEST

YES___NO___ SHORTNESS OF BREATH

YES___NO___ SWELLING OF THE ANKLES OR FEET

YES___NO___ RHEUMATIC FEVER OR SCARLET FEVER

YES___NO___ HIGH BLOOD PRESSURE

YES___NO___ LOW BLOOD PRESSURE

YES___NO___ DO YOU TIRE EASILY

YES___NO___ DO YOU BRUISE EASILY

YES___NO___ ASTHMA OR HAY FEVER

YES___NO___ HIVES OR SKIN RASH

YES___NO___ ARTHRITIS

YES___NO___ DIABETES

YES___NO___ FREQUENT HEADACHES

YES___NO___ LUNG PROBLEMS OR TB

YES___NO___ HEPATITIS, LIVER DISEASE OR JAUNDICE

YES___NO___ STOMACH ULCERS

YES___NO___ BLEEDING PROBLEMS

YES___NO___ ANEMIA

YES___NO___ KIDNEY DISEASE

YES___NO___ VENEREAL DISEASE, SYPHILIS OR GONORRHEA

YES___NO___ SINUS TROUBLE

YES___NO___ OTHER CHRONIC DISEASES

CHILDHOOD DISEASES_____

_____

Has patient ever had any reaction to dental anesthesia (gas or injections)? YES____NO____UNKOWN____

If yes, what?_____

Has patient ever had difficulty or prolonged bleeding following dental extractions

Has the patient ever received sedatives for dental procedures? YES____NO____UNKOWN____

If so, in what form was it given: GAS____ORALLY____INJECTION____UNKNOWN____

Were you pleased with the results of the sedation? YES____NO____UNKNOWN____

FEMALES: IS PATIENT PREGNANT? YES____NO____UNKNOWN____

Does patient have any problems associated with her menstrual period? YES____NO____UNKNOWN____

ADDITIONAL INFORMATION_____

_____

WHO REFERRED YOU TO OUR PROGRAM_____

COMMENTS_____

_____

_____

SIGNATURE OF PERSON FILLING OUT THIS FORM_____

DENTISTS SIGNATURE_____

DATE_____

IT IS IMPORTANT THAT YOU INFORM US OF ANY CHANGE IN PATIENT'S HEALTH OR MEDICATIONS

All information must be filled out. NA is not an acceptable answer.

Patient Name: _____ Date: _____

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: _____

The purpose of this questionnaire is to learn more about your child before beginning his (her) dental care. Please answer each question completely. Your answers will help to make your child's visit to the dentist more predictable and productive.

NAME _____ DATE _____

1. Is this your child's first visit to a dental office? YES _____ NO _____
   If not, describe previous visits:
   A. Length of last visit: _____
   B. Child's reaction to last visit: _____
   C. What type of treatment was accomplished? (example: exam, fillings, cleaning)
   _____
   D. Was a parent present in the treatment room with the child? YES ___ NO _____

2. How does your child normally react to a visit to a doctor's office? _____
   _____

3. Who brushes your child's teeth? _____
   How often is this done? _____
   Does your child recognize words such as mouth, teeth, open, close? YES __ NO _____

4. Can your child sit unassisted in a chair? YES _____ NO _____
   How long is your child's attention span while at home? (other than watching T.V.)
   _____

5. At what time of the day is your child most relaxed? _____

6. Will your child exhibit any habits or predictable reactions while under stress?
   Thumb sucking YES ___ NO _____ Physical resistance YES ____ NO _____
   Finger biting YES ___ NO _____ Other: _____
   Rocking or fidgeting YES ___ NO _____

7. Does your child distinguish between family members and strangers? YES _ NO _____
   Does your child obey "yes" and "no" commands? YES ____ NO _____

8. Does your child use specific methods of communication other than speech to express his (her) needs and desires?
   _____

9. How do you encourage or reward good behavior at home? _____
   _____

10. Does your child have a favorite toy, game, song, etc. that keeps him (her) occupied?
    Please specify: _____
    Can the child play with it in the dental office? YES _ NO _____

11. Does your child respond favorably to physical contact and reassurance from family members?
    YES ___ NO _____
    Does your child respond to verbal praise or reassurance? YES _____ NO _____

12. Is there any additional information that might help us in treating your child?
    _____

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:** _____

Parent/Legal Guardian, ~~Personal Representative~~)

If not signed by patient.

614 6/04

Patient Name_____

Address_____

Phone Number_____

Date of Birth_____

Medical Record Number_____

Advocate Health Care

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution Advocate Immc Dental Department

Address 811 W. Wellington

City Chicago State IL Zip 60657

TO: (Recipient) Person/Institution_____

Address_____

City_____ State_____ Zip_____

Purpose or need for information:_____

Disclosure will include: *(check all that apply)*

- ☒ Face Sheet
- ☒ History & Physical
- ☐ Laboratory Report
- ☒ Operative Report
- ☐ Itemized Bill
- ☐ Discharge Summary
- ☒ Progress/Physician Notes
- ☒ X-ray/Radiology Report
- ☐ Pathology Report
- ☒ Other Grants
- ☐ Emergency Report
- ☐ Nurses Notes
- ☐ EKG/EMG/EEG Report
- ☐ Consultation Report

Records for the period (dates) from _____ to _____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

_____ **Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse**

_____ **Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment**

_____ **Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.**

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian/Personal Representative (Required if Patient is not legally authorized to sign Authorization) Relationship to Patient

_____

Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Advocate Health Care cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

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SPECIAL DENTISTRY DEPARTMENT

APPOINTMENT CANCELLATION POLICY

As of January 1, 2021 There will be a charge of $51.00 for all failed appointments.

All appointments are scheduled in advance with our receptionist. Our receptionist takes the time to make sure patients are scheduled according to their treatment. She takes the time to fax or mail forms, and she also confirms all appointments. If you are unable to keep an appointment, we ask that you give our office at least 48 hours. Make sure all of our forms are filled out, with guardian's signatures.

If you fail to follow our cancelation policy, a $51.00 fee will be charged. We cannot schedule an appointment until fee is paid.

I have read and understand the department appointment cancellation policy.

Patient Name: _____ D.O.B_____

Patient/Guardian Signature: _____Date:_____

The dentist and staff of Special dentistry, Thank you for your cooperation

State of Illinois
Department of Human Services

Release of Information

I authorize the release of medical, financial, personal and other program information by AIMMC Dental Center agency, the fiscal/employer agent and by the Illinois Department of Human Services (DHS). This information may be released for the purposes of determining my eligibility for programs, planning my services and supports and monitoring my service delivery. The information may also be used to audit agencies providing my services and to review programs. Information may be released only if it is necessary to accomplish these purposes.

This release is valid until _____ **(Expiration Date).**
(Must be completed)

Agencies authorized to receive this information are the:

* U.S. Department of Health and Human Services;
* U.S. Social Security Administration;
* Illinois Departments of Human Services, Healthcare and Family Services, and Public Health;
* Other Illinois state agencies that operate a Medicaid Home and Community-Based Services waiver program;
* Illinois State Board of Education; and
* Local agencies under contract with DHS for the provision of service coordination, employer agent services or other supports and services which are involved in my individual service plan.

I understand that I have the right to look at and copy information about me that is released. I also understand that I have the right to refuse to release information but that DHS may still release information according to the Confidentiality Act and the federal Health Insurance Portability and Accountability Act (HIPAA).

Name of Individual (print or type): _____

Signature of Individual or authorized representative: _____

Signature of Witness: _____ Date: _____

CONFIDENTIALITY OF INFORMATION - Information received about the individual is to be handled in accordance with the requirements of the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and the federal Health Insurance Portability and Accountability Act (HIPAA).

(formerly DMHDD - 1214)