# Chapel & Keller Dentistry Partnership

www.chapelandkeller.com

4113 Humbert Rd. • Alton, IL 62002 (618)465-7777

## Welcome to our Practice

**Chart#:** ____________
FOR OFFICE USE ONLY

**Patient Name:** ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

**Title:** ________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

**Birth Date:** ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

**Email Address:** ____________ **Best time to call:** ____________

**Phone:** ________ (Home) ________ (Mobile) ________ (Work) ____ (Ext) ________ (Fax) ________ (Other)

**Address:** ____________ (Address 1) ____________ (Address 2)

____________ (City) ____ (State) _____-____ (Zip Code)

**Whom may we thank for referring you to our practice?**

**Referral Name:** ____________

**In an emergency who should be notified? Please enter Name and Phone number below:**

**Emergency Contact:**

____________

____________

## Responsible Party Information:

**This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.**

**The following is for:** ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

**Name:** ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

**Title:** ________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

**Birth Date:** ____________ **SS#:** ___-__-____ **DL#:** ____________

**Email Address:** ____________ **Best time to call:** ____________

**Phone:** ________ (Home) ________ (Mobile) ________ (Work) ____ (Ext) ________ (Fax) ________ (Other)

**Address:** ____________ (Address 1) ____________ (Address 2)

____________ (City) ____ (State) _____-____ (Zip Code)

## Primary Dental Insurance:

**Name of Insured:** ______________________ ______________________ ____
Last First MI

**Insured's Birth Date:** ______________

**ID #:** ______________ **Group #:** ______________

**Insured's Address:** ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

**Insured's Employer Name:** ______________________

**Employer Address:** ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** ______________________

**Insurance Address:** ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

## Secondary Dental Insurance:

**Name of Insured:** ______________________ ______________________ ____
Last First MI

**Insured's Birth Date:** ______________

**ID #:** ______________ **Group #:** ______________

**Insured's Address:** ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

**Insured's Employer Name:** ______________________

**Employer Address:** ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** ______________________

**Insurance Address:** ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

☐ **By checking this box,**
**I authorize my insurance company to pay the dentist all insurance benefits rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges whether or not paid by insurance.**

## Dental Information

**What is your immediate dental concern?**

______________________________________________

______________________________________________

**Previous Dentist Name and Phone Number:**

______________________________________________

______________________________________________

**Date of most recent dental exam and dental x-rays:**

______________________________________________

______________________________________________

**Is there anything about the appearance of your smile that you would like to change?**

______________________________________________

______________________________________________

**Check all that apply:**

- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Had any reactions to local anesthetic
- [ ] Had/have braces, orthodontic treatment
- [ ] You experience dry mouth
- [ ] Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- [ ] Food gets trapped between any teeth
- [ ] Have you ever whitened or bleached your teeth
- [ ] Have you experienced popping and/or clicking of your jaw joint
- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth
- [ ] You wear or have worn a bite appliance
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] You snore or wake up frequently during the night

**If any of the checked boxes need further explanation, please describe:**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

## Consent for Services and Financial Policy

Because your time is important to you, we will make every effort to begin your dental appointment on schedule. We, in turn, will depend on you to keep your scheduled appointment. We require 48 hours notice so that we may provide treatment for others. Appointments that are broken with less than 48 hours notice are subject to pre-payment in advance to secure the

next appointment time.

FIVE YEAR GUARANTEE: The patient must continue to keep their regularly scheduled hygiene appointments in order for restorative work to be guaranteed due to breakage. Not decay.

INSURANCE: We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us. Also, there are constant changes being made with your coverage, deductibles, and annual maximums by your employer and the insurance company that are not being shared with us. Therefore it is impossible for us to know exactly what your policy covers and you are ultimately responsible for all fees for dental services rendered. In order for us to maintain our high level of service to you the patient, we continue to provide the courtesy of submitting the claim on your behalf and supporting your with maximizing your benefits of your policy. However, we are no longer able to carry your insurance balance for longer than 30 days. Policy coverage changes and follow up on un-paid claims is your responsibility. We ask that if you have any questions about an unpaid claim or coverage that you immediately contact your insurance company directly as they will answer to you because you are the policy holder. Ultimatly all fees for dental services rendered are your responsibility.

- All Copays are due in full at time of service.
- All Accounts that are turned over to Collections will be charged a 30% collection fee.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

**Name and Relationship to Patient:**

______________________________

______________________________

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

**Name of patient, parent of guardian completing this form:**

______________________________

______________________________

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**Response Date:** ____________