# Financial and Insurance Protocol

At our office, we believe that you deserve the best care possible. That's why we always present you with the best dental solution available to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

_____Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly.**

_____We currently accept all private care insurance plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payments by any given company, companies do change. It is impossible to give you a guaranteed quote at the time of service due to these changes. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** A balance on your account may exist occasionally due to the amount of payment our office received from your insurance company. You are then responsible for the remaining balance. We will be happy to file a "pre-treatment" with your insurance company if you would like to know your insurance benefit prior to treatment being performed. Keep in mind that this is not a guarantee of coverage.

_____We will bill your insurance as a courtesy. Our office reserves the right to request payment from you for the full amount for services if insurance does not pay within 90 days, and let you collect any insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Ultimately, you are responsible for all charges incurred in our office.

_____Bloomington Modern Dentistry does require payment in full at the time of service. We currently accept Master Card, Visa, Discover, American Express, Cash and Checks. We also work with Care Credit, a company which offers up to 12-month interest free payments with approved credit if you are in need of extended finance options. We reserve the right to charge a finance fee of 1.5% for accounts that are over 30 days due. Your account will be subject to collections if the balance is not paid within 90 days, and as a result, you will also be responsible for any collections fee incurred during the process.

_____A pre-determined amount of time is reserved specifically for you. Therefore, we strongly encourage all patients to keep their appointments. We require **at least 48 hour notice** to make any changes to your appointment. A **$35/hour fee** will be applicable to any appointment that is broken/missed without proper notification to our office staff (emergencies are an exception). **If you are unable to keep an appointment please call (309)662-5921 until you are able to reach someone in our office. We will not accept any message left on the voicemail as a notification of any changes to your appointment.**

_____In the event of a dental emergency after regular business hours, a **$35 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a **$125 after hours emergency fee**.

**I agree with the above conditions.**

Print Name: _____Date:_____

Patient/Parent Signature: _____

**Entire Family**

**Individual**

bloomington
MODERN DENTISTRY

Name: _____
Last First MI

Preferred Name: _____ Date of Birth: ____/____/____

SSN: _____ Gender: Male Female

Address: _____
Street City State Zip

Contact Numbers: _____
Best Phone Work Phone

Do you have dental benefits? Yes No If Yes, please complete below:

Policy Holder Name: _____

Policy Holder DOB: ____/____/____ Policy Holder Social Security #: ____-____-____

Policy Holder Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

# Acknowledgement of Receipt of Notice of Privacy Practices

## I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices

Print Name:_____(____Self_____Parent_____Guardian)

Signature:_____

Name of Patient:_____

Date:_____

**Patient Contact:**
**All calls regarding care and appointments will be made to the phone number provided to us to confirm and follow-up with you.**

**If you would like us to contact you at an alternate number please list it below:**

Phone#:_____

May we leave a message on your home voicemail?

_____Yes _____No

---

FOR OFFICE USE ONLY

---

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

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)_____

Bloomington Modern Dentistry

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications, pills, or drugs? | Yes No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Are you on a special diet? | Yes No | |
| Do you use tobacco? | Yes No | |

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

| | | |
|---|---|---|
| Other? | ☐ | If yes |
| Do you use controlled substances? | Yes No | If yes |

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | Cortisone Medicine | Yes No | Hemophilia | Yes No | Radiation Treatments | Yes No |
| Alzheimer's Disease | Yes No | Diabetes | Yes No | Hepatitis A | Yes No | Recent Weight Loss | Yes No |
| Anaphylaxis | Yes No | Drug Addiction | Yes No | Hepatitis B or C | Yes No | Renal Dialysis | Yes No |
| Anemia | Yes No | Easily Winded | Yes No | Herpes | Yes No | Rheumatic Fever | Yes No |
| Angina | Yes No | Emphysema | Yes No | High Blood Pressure | Yes No | Rheumatism | Yes No |
| Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No | High Cholesterol | Yes No | Scarlet Fever | Yes No |
| Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No | Hives or Rash | Yes No | Shingles | Yes No |
| Artificial Joint | Yes No | Excessive Thirst | Yes No | Hypoglycemia | Yes No | Sickle Cell Disease | Yes No |
| Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No | Sinus Trouble | Yes No |
| Blood Disease | Yes No | Frequent Cough | Yes No | Kidney Problems | Yes No | Spina Bifida | Yes No |
| Blood Transfusion | Yes No | Frequent Diarrhea | Yes No | Leukemia | Yes No | Stomach/Intestinal Disease | Yes No |
| Breathing Problems | Yes No | Frequent Headaches | Yes No | Liver Disease | Yes No | Stroke | Yes No |
| Bruise Easily | Yes No | Genital Herpes | Yes No | Low Blood Pressure | Yes No | Swelling of Limbs | Yes No |
| Cancer | Yes No | Glaucoma | Yes No | Lung Disease | Yes No | Thyroid Disease | Yes No |
| Chemotherapy | Yes No | Hay Fever | Yes No | Mitral Valve Prolapse | Yes No | Tonsillitis | Yes No |
| Chest Pains | Yes No | Heart Attack/Failure | Yes No | Osteoporosis | Yes No | Tuberculosis | Yes No |
| Cold Sores/Fever Blisters | Yes No | Heart Murmur | Yes No | Pain in Jaw Joints | Yes No | Tumors or Growths | Yes No |
| Congenital Heart Disorder | Yes No | Heart Pacemaker | Yes No | Parathyroid Disease | Yes No | Ulcers | Yes No |
| Convulsions | Yes No | Heart Trouble/Disease | Yes No | Psychiatric Care | Yes No | Venereal Disease | Yes No |
| | | | | | | Yellow Jaundice | Yes No |

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____