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**.

Entire Family Individual



Name:					MI	
Last		First				
Preferred Name:		<u>Date of Birth</u>	h:	//	//	
SSN:		<u>Gen</u>	nder:	Male	Female	
Address:						
Street	City			State		Zip
Contact Numbers:						
	Best Phone		Work Phone			
Do you have dental benefits?	Yes No	If Ye	es, pleas	e complete be	low:	
Policy Holder Name:						
Policy Holder DOB: /	/ Policy Ho	lder Social Secur	rity #:			
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:	_(Se	lf	Parent	Guardian)
Signature:				
Name of Patient:				
Date:				
Patient Contact: All calls regarding care and appointments provided to us to confirm and follow-up wi			le to the p	hone number
If you would like us to contact you at an al	ternate	nun	nber plea	se list it below:
Phone#:				
May we leave a message on your home voicemail?				
YesNo				
FOR OFFICE	USE O	NLY		
We attempted to obtain written acknowled Privacy Practices, but acknowledgement c	gemen	t of r	eceipt of	our Notice of
Individual refused to sign				
Communication barriers prohibited obtaining the	acknowl	edger	ment	
An emergency situation prevented us from obtai	ning ackı	nowle	dgement	
Other (Please Specify)				

Bloomington Modern Dentistry
Eaglesoft Medical History
Birth Date:

Patient Name:

Date Created:

Alzheimer's DiseaseYesNoDiabetesYesNoHepatitis AYesNoRecent Weight LossYesYesAnaphylaxisYesNoDrug AddictionYesNoHepatitis B or CYesNoRenal DialysisYesYesYesAnemiaYesNoEasily WindedYesNoHepatitis B or CYesNoRenal DialysisYesY	medication that you may	be taking, could	d have an important inter	elationship with	the dentistry you will reco	eive. Thank you	Ith problems that you may for answering the following	questions.
laperation? Have you ever had a serious head or neck injury? Have you ever had a serious head or neck injury? Are you take, or have you taken, Phen-Fen or Redux? Do you take, or have you taken, Phen-Fen or Redux? Yes © No Do you use, taken fossmax, Bonka, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Orgon a special diet? Yes © No Do you use tobacco? Yes © No Pregnant/Trying to get pregnant? Pregnant/Trying to get pregnant	Are you under a physician's care now?		🔘 Yes (No If yes	1			
heve 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 Are you taking any medications, pills, or drugs? Yes No If yes Are you take, or have you taken, Foarmax, Bonko, Actonel Or Yes No If yes Are you attaken, Foarmax, Bonko, Actonel Or Yes No If yes Are you an a special diet? Yes No Do you use tobacco? Yes No Article any of the following? Yes No Article any of the following? If yes No If yes Are you an a special diet? No State Foarma Yes No Article and Artylic Codeline Active any of the following? If yes No If yes Are you also got any of the following? Yes No If yes Are you also got any of the following? Yes No If yes Are you also got any of the following? Yes No If yes Are you also got any of the following? Yes No If yes Are you also got any of the following? Yes No If yes Are you also got any of the following? Yes No If yes Are you had, any of the following? Yes No If yes Aremia Yes No Ioug Addiction Yes No Ioug Addiction Yes No Ioug Addiction Yes No Hepatitis A Yes No Recent Weight Loss Yes Or Anaphylaxis Are Yes No Easily Winded Yes No Hepatitis A Yes No Recent Weight Loss Yes Or Arthritig/Out Yes No Easily Winded Yes No Hepatitis A Yes No Recent Weight Loss Yes Or Arthritig/Out Yes No Easily Winded Yes No Hepatitis A Yes No Recent Weight Loss Yes Or Arthritig/Out Yes No Easily Winded Yes No Hepatitis A Yes No Scale Forever Yes Or Arthritig/Out Yes No Easily Winded Yes No Hepatite Yes No Scale Forever Yes Or No Arthritig/Out Yes No Frequent HeadAcles Yes No Hepatite Yes No Scale Forever Yes Or No Frequent HeadAcles Yes No Hepatite Yes No Scale Forever Yes Or No Gravel Head Yes No Frequent HeadAcles Yes No Hepatite Yes No Scale Forever Yes Or No Gravel Head Yes No Frequent HeadAcles Yes No Hepatite Yes No Scale Forever Yes Or No Gravel HeadAcles Yes No Hepatite Yes No Scale Forever Yes Or Or Conserver Wes No Head Yes No Hepatite Aret Yes No Scale Forever Yes Or Or Conserver Wes No Frequent HeadAcles Yes No Hepaty Proviso Prosone Yes No Sc	571	pitalized or had	a major 💮 Yes 🖗	No If yes				
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	Convulsions	🔘 Yes 🔘 No	the second second	🔘 Yes 🔘 No		marchael construction		🔘 Yes 🔘 N
Have you ever had any serious illness not listed 💿 Yes 💿 No 🛛 If yes							Yellow Jaundice	O Yes O N
	Have you ever had any	serious illness r	not listed 🔘 Yes (No If ye	5			

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: