Parkway View Family Dentistry

Today's Date ______________________

Dr. Gregory Solis, DDS, Dr. Sarah Ade Wallace, DMD, and Dr. Benjamin Marine, DMD
7017 John Deere Pkwy, Suite 2B, Moline, IL 61265
1101 Albany Street, Erie, IL 61250

Welcome to our office. Please fill out the following information as completely as possible. Please print clearly.

PATIENT INFORMATION

Title ☐ Mr ☐ Mrs ☐ Ms ☐Miss ☐ Dr
Name ____ I prefer to be called_______________________________
Address ______________________________________ City________________________ State_______ Zip______________
Phone Cell:________________________________ Work:___________________________ Home:____________________
Date of Birth ______________________ Social Security Number _________________________ Sex ☐ Male ☐ Female
Email Address ____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employer ____ Occupation____
If student, Name of School ____________________________________ City/State __________________________________
Whom may we thank for referring you? ____
Person to contact in case of emergency ____________________________________ Phone_____________________________
Person who is financially responsible for this bill ____

HUSBAND/FATHER	WIFE/MOTHER
Name ________________________________	Name ________________________________
Address ______________________________	Address ______________________________
City/State/Zip __________________________	City/State/Zip __________________________
Home # _______________________________	Home # _______________________________
Cell # ________________________________	Cell # ________________________________
Employer _____________________________	Employer_____________________________
DOB _______________SS# ___________________	DOB ________________SS# _________________

Do you have Dental Insurance ☐ Yes ☐ No

PRIMARY SUBSCRIBER'S INSURANCE INFORMATION

Name of Insured ______________________________ DOB ___________________Relationship to patient _______________
SS# _________________________________ Name of Employer ____
Address of Employer ____ Cell Phone __________________________
Insurance Company _________________________________ Group# _____________________ ID# ______________________
Do you have any additional insurance ☐ Yes ☐ No

SECONDARY SUBSCRIBER'S INSURANCE INFORMATION

Name of Insured ______________________________ DOB ___________________Relationship to patient _______________
SS# _________________________________ Name of Employer ____
Address of Employer ____ Cell Phone __________________________
Insurance Company _________________________________ Group# _____________________ ID# ______________________

We make every effort to keep down the cost of your comprehensive dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office depending upon special circumstances. **An estimate of the charge for any procedure will be given to you upon request.** If you have any dental insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form. If insurance is involved, **it is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.**

Signature of patient (or guardian, if minor) _______________________________________ Date ______________________

This signature on file is my authorization for the release of information, including any Protected Health Information necessary to process my claim. I hereby authorize and direct payment to the doctor named of the benefits otherwise payable to me.

Signature of patient (or guardian, if minor) _______________________________________ Date ______________________

PATIENT'S NAME ______________________________ Date of Birth ____________ Date ____________

DENTAL HISTORY

Reason for visiting us today ______________________________

If you could change one thing about your smile, what would it be ______________________________

Former Dentist ______________________________ City/State ______________________________

Date of last visit ______________ Reason for last visit: ☐ Cleaning/Check-up ☐ Fillings ☐ Tooth Extraction ☐ Other

Date of last Xrays ______________ Type of Xrays taken: ☐ Bitewings ☐ Full Mouth Series ☐ Panorex ☐ Don't Know

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

☐ Bad Breath
☐ Bleeding Gums
☐ Tender or Swollen Gums
☐ Periodontal Treatment
☐ Dry Mouth
☐ Sensitivity to Hot/Cold
☐ Sharp/Throbbing Pain
☐ Sensitivity when biting
☐ Loose Teeth/Broken Fillings
☐ Burning Sensation
☐ Cold Sores/Canker Sores
☐ Growth In Mouth
☐ Jaw Pain/Tiredness
☐ Clicking/Popping Jaw
☐ Grinding/Clenching Teeth
☐ Gagging
☐ Mouth Breather
☐ Tongue Thrusting
☐ Thumb Sucking
☐ Orthodontics

MEDICAL HISTORY

Primary Care Physician's Name ______________________________ City/State ______________________________

Physician's Phone Number ______________________________ Date of last visit ______________________________

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

Y N

☐ ☐ Artificial Heart Valves
☐ ☐ Prosthetic Joint Replacement
☐ ☐ Blood Thinner Medication
☐ ☐ Mitral Valve Prolapse or Heart Murmur
☐ ☐ Stroke or Cardiovascular Disease
☐ ☐ High/Low Blood Pressure (circle one)
☐ ☐ Organ Transplant
☐ ☐ Pacemaker
☐ ☐ Congestive Heart Failure
☐ ☐ Congenital Heart Disorder
☐ ☐ Heart Problems/Disease/Surgery
☐ ☐ Epilepsy or Seizures
☐ ☐ Diabetes
☐ ☐ Rheumatic Fever

Y N

☐ ☐ Kidney Dialysis
☐ ☐ Kidney Problems
☐ ☐ Asthma
☐ ☐ Lung/Breathing Disorders
☐ ☐ Tuberculosis
☐ ☐ Liver Disease
☐ ☐ Hepatitis A, B, or C (circle one)
☐ ☐ Jaundice
☐ ☐ Ulcers/GERD/Acid Reflux
☐ ☐ Alzheimer's Disease/Dementia
☐ ☐ Glaucoma
☐ ☐ Headaches
☐ ☐ Thyroid Problems
☐ ☐ Osteoporosis/osteoporosis med
☐ ☐ *Human Papillomavirus* (HPV)

Y N

☐ ☐ Arthritis and/or Rheumatism
☐ ☐ Blood Disorder
☐ ☐ Anemia
☐ ☐ HIV/AIDS
☐ ☐ Cancer
☐ ☐ Chemotherapy Treatments
☐ ☐ Radiation Treatments
☐ ☐ Psychiatric Care
☐ ☐ Chemical or Drug Dependency
☐ ☐ Phen-Fen/Redux in the past
☐ ☐ Hearing or Vision Impaired

For Women Only:

☐ ☐ Are you pregnant?
☐ ☐ Currently Breast Feeding?
☐ ☐ *Taking oral contraceptives?*

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, please explain ______________________________

Have you had a serious illness or operation not listed? ______________________________

Do you use tobacco? ☐ Yes ☐ No If yes, how much do you use ______________________________ # of years ____________

Allergies: ☐ Penicillin ☐ Latex ☐ Codeine ☐ Aspirin ☐ Sulfa ☐ Local Anesthetics
☐ Barbituates ☐ Iodine ☐ Acrylic ☐ Metal ☐ Food Allergy ☐ Other ____________

Medications: **Please list any medications you are currently using, including over-the-counter medication/supplements.**

____
____
____

I have read and understand the above questions and to the best of my knowledge, the questions on this form have been accurately answered. I understand 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 (or guardian, if minor) ______________________________ Date ____________

OUR FINANCIAL POLICY – Parkway View Family Dentistry LTD

INFORMATION

Prior to receiving service, you must complete our patient forms and any necessary insurance forms, as well as provide your insurance card and a driver's license for photocopying.

INSURANCE

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary.

You are responsible for the timely payment of your account. You will be responsible for any services and any deductibles or other amount not covered by your insurance company. If we can determine these amounts at the time of service, you will be asked for payment at that time**. It is your responsibility to know the terms and conditions of your insurance coverage. It is also your responsibility to follow up to be sure that your insurance company has paid for your services, whether or not you are notified of any problems by this office. It is your responsibility to notify us of any changes in insurance.**

If you have no proof of insurance or if your insurance coverage cannot be verified, payment is due in full at the time of service. We will be happy to fill out an insurance form at a later date so the insurance company can reimburse you directly.

PARTICIPATING PROVIDER

At this time, we are a Premier Participating Provider with all Delta Dental insurance plans. You are welcome to use your current insurance if it is a different insurance company, however it will pay your claim as a non-participating provider.

SELF PAY

If you do not have insurance, payment is expected in full at the time of service. Payments plans can be arranged on a limited basis. We accept cash, checks and most major credit cards.

POLICY FOR LARGE TREATMENT PLANS

If a treatment plan consists of extensive procedures, the office may require 50% down to begin the procedure. The remaining 50% will be due upon completion or financing options may be available. Talk to our front desk staff.

PROCEDURES NOT COVERED BY INSURANCE COMPANIES

Insurance companies will not cover procedures and devices that they deem cosmetic in nature, for example, whitening treatments, veneers, snoreguards, etc. For this reason, payment of such procedures is typically required at the time of service.

LITIGATION

Patients involved in an auto accident, worker's compensation case, personal injury lawsuit, school related injury or all other accidents, are responsible for payment in full at the time of service. We will, as a courtesy, send your attorney a statement of your charges if you provide us with a name and address.

I have read the above policy and understand my responsibility for my (or my family member's) account.
Signed ____ Date____________________________________
If applicable, I am financially responsible for (minor patient's name) ____

All past due accounts or accounts failing to make adequate financing payments, are subject to a finance charge of 1.5% per month or maximum rate allowed by law. The undersigned, agrees to be personally responsible for all charges, if at any time, or for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Parkway View Family Dentistry Ltd. to bill their account finance charges as described above. In the event it becomes necessary for Parkway View Family Dentistry Ltd. to incur collection costs or institute suit to collect any amount due under this agreement, the undersigned also agrees to pay collection fees and expenses, including reasonable attorneys' fees and court cost plus all legal fees if incurred for collection and submits to jurisdiction and venue in Rock Island County, IL. I hereby certify that I have read and agree to the terms.
Signed ____ Date___________________________________

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Parkway View Family Dentistry Ltd of their Notice of Privacy Practices for patients, which is displayed in the dental office, and contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.
I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the following address to obtain a current copy of their Notice of Privacy Practices:

Parkway View Family Dentistry
7017 John Deere Pkwy.
Suite 2B
Moline, IL 61265
309-792-0513

OR

Parkway View Family Dentistry
PO Box 850
1101 Albany Street
Erie, IL 61250
309-659-2201

I understand that I may request, in writing, that Parkway View Family Dentistry Ltd. restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Parkway View Family Dentistry Ltd is not required to agree to my requested restrictions, but if they do agree, then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relaying on this consent.

Patient Name ____

Signature ____

Relationship to Patient ____

Date ____