

# Patient Registration-Insurance and Financial Agreement Form

Associates for Family Dentistry, Ltd.

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Date: \_\_\_\_\_

Patient #: \_\_\_\_\_

## \*\*\*Responsible party

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Circle marital status:    single    married    separated    widowed

Employer:

Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Employer phone \_\_\_\_\_ Ext \_\_\_\_\_

Do you have dental insurance?    Y    N    If yes, complete insurance information form

Name of spouse \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse employer \_\_\_\_\_ SSN \_\_\_\_\_

Employer address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Employer phone \_\_\_\_\_ Ext \_\_\_\_\_

## \*\*\*Patient information

Name \_\_\_\_\_ circle:    male    female

Birthdate \_\_\_\_\_ circle relationship:    self    spouse    child    other \_\_\_\_\_

Referred by \_\_\_\_\_

In case of emergency contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone number \_\_\_\_\_

I have read the financial agreement attached, and I have received a copy of this financial agreement.

Please give 24 hours notice if you cannot keep an appointment. A charge will be rendered for broken appointments.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Responsible party or authorized member of family)

## Medical Information

Name of patient being seen today \_\_\_\_\_ Date: \_\_\_\_\_  
Patient number: \_\_\_\_\_

Your medical doctor's name (not your dentist) and location:

1. How long since your last dental examination? \_\_\_\_\_  
What was done at that time? \_\_\_\_\_
2. Are you having any problems with your teeth or gums now? \_\_\_\_\_  
**If yes, what?** \_\_\_\_\_
3. Are you currently under the care of a physician? \_\_\_\_\_  
**If yes, for what purpose?** \_\_\_\_\_
4. Please list any medications you are presently taking and for what reason: \_\_\_\_\_
5. Have you ever been in the hospital? **If yes, for what purpose?** \_\_\_\_\_

6. Are you allergic to: \_\_\_ Penicillin \_\_\_ Codeine \_\_\_ Latex \_\_\_ Local anesthetic  
Other medication, please list \_\_\_\_\_
7. Do you frequently feel faint or dizzy? \_\_\_\_\_
8. Are you subject to prolonged bleeding? \_\_\_\_\_
9. Do you wear a pacemaker? \_\_\_\_\_
10. Do you wear glasses or contacts? \_\_\_\_\_
11. Do you smoke or use tobacco products? \_\_\_\_\_
12. Do you have a knee or hip replacement/other prosthesis? \_\_\_\_\_
13. Do you have mitral valve prolapse? \_\_\_ Yes \_\_\_ No
14. Have you ever taken any of the following appetite suppressants: Fenfluramine (Pondimin) or Dexphenfluramine (commonly referred to as fen-phen)? \_\_\_\_\_
15. **Women:** Are you pregnant? \_\_\_\_\_ Due date \_\_\_\_\_
16. Have you ever been treated for osteoporosis? \_\_\_\_\_
17. Have you ever taken Fosamax, Actonel, Aredia, Zometa, Boniva? \_\_\_\_\_

18. Please answer the following if it applies to you:  
Are you undergoing chemotherapy? \_\_\_\_\_  
Are you undergoing radiation? \_\_\_\_\_  
Have you had chemotherapy? \_\_\_\_\_  
Have you had radiation? \_\_\_\_\_

19. Place an 'X' next to any of the following you have or had:

- |                         |                     |                    |  |
|-------------------------|---------------------|--------------------|--|
| ___ High Blood Pressure | ___ Heart Surgery   | ___ Diabetes       | ___ Asthma                                     |
| ___ Low Blood Pressure  | ___ Rheumatic Fever | ___ Kidney Disease | ___ Pneumonia                                  |
| ___ Heart Disease       | ___ Liver Disease   | ___ Dialysis       | ___ Tuberculosis                               |
| ___ Heart Murmur        | ___ Hepatitis A     | ___ Ulcer          | ___ Venereal disease                           |
| ___ Anemia              | ___ Hepatitis B     | ___ Acid Reflux    | (syphilis, gonorrhea,<br>genital herpes, etc.) |
| ___ HIV/AIDS            | ___ Hepatitis C     |                    |  |

**Insurance Information Form**

Patient Name \_\_\_\_\_

Patient # \_\_\_\_\_

**\*\*\*Primary Insurance Information\*\*\***

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Employer Name \_\_\_\_\_ Telephone# \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insurance company name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Group/Policy # \_\_\_\_\_

**\*\*\*Secondary Insurance Information\*\*\***

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (Cell) \_\_\_\_\_

Employer Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

SSN \_\_\_\_\_ Subscriber # \_\_\_\_\_

Insurance company name \_\_\_\_\_ Telephone# \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Group/Policy # \_\_\_\_\_

**Assignment of Benefits:** I authorize payment directly to the provider named. I also authorize release of any dental information necessary to process any dental claims.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Please have your insurance cards available for us to copy. Thank you for your assistance!**

## FINANCIAL AGREEMENT

1. I agree to pay the amount charged by the doctor for all professional treatment and services to the undersigned, his/her family or to the patient indicated on the front.
2. Sixty days after statement closing date (always a minimum of 50 days from date of service), I agree to pay the doctor a **FINANCE CHARGE** computed at the periodic rate allowable by law in the state in which I reside in as follows.
3. This **FINANCE CHARGE** will be applied to my adjusted balance (previous balance after deducting current payments and/or credits appearing on my statement).
4. I can avoid incurring a **FINANCE CHARGE** by paying my account balance in full upon receipt of statement provided that payment is actually received by doctor before the next billing date. This allows for a minimum of 60 days from date of service to pay my account without incurring a **FINANCE CHARGE**.

Patient's Residence	Monthly Periodic Rate	Annual Percentage Rate	Patient's Residence	Monthly Periodic Rate	Annual Percentage Rate
Alabama	1-3/4% on Balance under 750 1-1/2% on Portion over 750	21% 18%	Kansas	1-3/4% on Balance under 300 1-1/2% on Next Portion under 1,000 1/2% on Portion over 1,000	21% 18% 14.4%
Alaska	1-1/2% on Balance under 1,000 1% on Portion over 1,000	18% 12%	Maryland, Hawaii, District of Columbia	2% on Full Balance	24%
Arkansas	5/6% on Full Balance	10%	Michigan	1.7% on Full Balance	20.4%
California	1.6% on Balance under 3,000 1.0% on Portion over 3,000	19.2% 12.0%	Mississippi	1-3/4% on Balance under 800 1-1/4% on Next Portion under 1,200 1% on Portion over 1,200	21% 15% 12%
Colorado, Georgia, Idaho, Indiana, Oklahoma, Rhode Island, Tennessee, Wyoming	1-3/4% on Full Balance	21%	Nebraska	1-3/4% on Balance under 500 1-1/2% on Portion over 500	21% 18%
Arizona, Connecticut, Delaware, Florida, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Virginia, Washington	1-1/2% on Full Balance	18%	Puerto Rico	2.17% on Full Balance	26%
Illinois, Nevada	1.8% on Full Balance	21.6%	Texas	1-1/2% on Balance under 1,450 1% on Portion over 1,450	18% 12%
Iowa, Vermont	1-1/2% on Balance under 500 1-1/4% on Portion over 500	18% 15%	Utah	1.63% on Full Balance	19.6%
			West Virginia	1-1/2% on Balance under 750 1% on Portion over 750	18% 12%
			Wisconsin	1-1/2% on Balance under 1,000 1-1/4% on Portion over 1,000	18% 15%

### IN CASE OF BILLING ERRORS OR INQUIRIES ABOUT YOUR BILL The Federal Truth in Lending Act requires prompt correction of billing mistakes.

- I. If you want to preserve your rights under the Act here's what to do if you think your bill is wrong or you need more information about an item on your bill.
  - A. Do not write on the bill. On a separate sheet of paper write the following (You also may telephone your inquiry, but doing so will not preserve your rights under this law.)
    1. Your name and account number.
    2. A description of the error and an explanation (to the extent you can explain why you believe it is an error).  
If you only need more information explain the item you are not sure about and if you wish ask for evidence of the charge. Do not send in your copy of any document relating to such charge unless you have a duplicate copy for your records.
    3. The dollar amount of the suspected error.
    4. Any other information (such as your address) which you think will help us to identify you or the reason for your complaint or inquiry.
  - B. Send your billing error notice to:

Associates for Family Dentistry, Ltd.  
101 S. Greenleaf Avenue, Suite E  
Gurnee, IL 60031

Mail it as soon as you can, but in any case, early enough to reach us within 60 days after the bill was mailed to you.

- II. We must acknowledge all letters pointing out possible errors within 30 days of receipt unless we are able to correct your bill during that 30 day period. Within 90 days after receiving your letter we must either correct the error or explain why we believe the bill was correct. Once we have explained the bill we have no further obligation to you even though you still believe there is an error except as provided in Paragraph V below.
- III. After we have been notified, neither we nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount in dispute, but periodic statements may be sent to you and the disputed amount can be included in determining your present account balance. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. However, you remain obligated to pay that portion of your bill which is not in dispute.
- IV. If it is determined that we have made a mistake on your bill, you will not have to pay any **FINANCE CHARGES** on any disputed amount. If it turns out that we have not made an error, you may have to pay **FINANCE CHARGES** on the amount in dispute and you will have to make up any missed minimum or required payments on the disputed amount. Unless you have agreed that your bill was correct, we must send you a written notification of what you owe, and if it is determined that we did make a mistake in billing the disputed amount, you must be given the time to pay which you normally are given to pay undisputed amounts before any more finance charges or late payment charges on the disputed amount can be charged you.
- V. If the explanation given by us does not satisfy you and you notify us in writing within ten days after you receive its explanation and you still refuse to pay the disputed amount, we may report you to credit bureaus and other creditors and may pursue regular collection procedures. But we must also report that you think you do not owe the money and we must let you know to whom such reports were made. Once the matter has been settled between you and us the resolution of the matter must be reported by us to all parties to whom it has originally reported you as delinquent.
- VI. If we do not follow these rules, we are not allowed to collect the first \$50.00 of the disputed amount and finance charges even if the bill turns out to be correct.

The Federal Equal Credit Opportunity Act prohibits from discriminating against applicants on the basis of sex or marital status. The Federal agency which administers compliance with this law concerning this doctor is the Federal Trade Commission, 55 East Monroe Street, Chicago, Illinois 60603.