Rosario Salerno Dental Care LLC
373 South Schmale Road, Suite 101
Carol Stream, IL 60188
(630) 668-9190

Patient Information

Date ____________________

Patient Name: ____________________ Date of Birth ____________________
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child ☐ Other Social Security#: ________________ *DL#:* ____________________

Phone (Home): ____________________ (Work): ____________________ (Ext): ________ (Mobile): ____________________

Email Address: ____________________ Which way do you prefer that we contact you? ____________________

Address: ____________________
Street Apartment #
____
City State Zip Code

Employer Name ____________________ Occupation ____________________

Health Information

Have you ever had or have any of the following? Please check those that apply:

☐ AIDS
☐ Allergies ___________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer, type? ________________
☐ Diabetes, type? ______
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding, please explain what caused it
____
☐ Fainting
☐ Glaucoma
☐ Gum Disease

☐ Headaches Migraine? __________
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis, type? ______
☐ High Blood Pressure
☐ Lung Disease
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Oral Cancer or lesion
☐ Pacemaker
☐ Pregnancy (presently) Due date: __________
☐ Radiation Treatment, When? ______________
☐ Respiratory Problems

☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

Please list any other drug allergies not mentioned here
____
____
____

Please list any PRESCRIPTION and/or OTC (Over The Counter) drugs you are currently taking, including vitamins or herbs.
____
____
____

Is there anything not listed here concerning your medical history we need to know about? ☐ Yes ☐ No
If yes, please explain:
____
____
____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Name of Physician: ____________________ Phone: ____________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________________

Name of person or office referring you to our practice: ____________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #- Birth Date:

Phone (Home): (Work): Ext: Best time to call:

Address:

Street Apartment #

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Occupation:

Do we have your permission to contact you at your work number? ☐ Yes ☐ No

Address:

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: Is insured a patient? ☐ Yes ☐ No

Last First M1

Insured's Birth Date: ID #: Group #:

Insured's Address:

Street City State Zip Code

Insured's Employer Name:

Address:

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address:

Secondary

Name of Insured: Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ID #: Group #:,

Insured's Address:

Street City State Zip Code

Insured's Employer Name:

Address:

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address:

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services, This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1%% per month (1 8% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: Relationship to Patient:

Signature of patient, parent or guardian

Date: Relationship to Patient:

Signature of guarantor of payment/responsible party

New Patient Insurance Registration Form

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different with lower premium plans covering fewer services and lower fees for services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turn around.
3. Researching your dental insurance plan to advise you of estimated benefits available to you.
4. Re-filing your insurance a second time at 30 days and a final time at 60 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **Please sign the "assignment of benefits" below** to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize **Dr. Salerno** to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. **Salerno** I understand I am responsible for any unpaid balance.

_________________________________ Date______________

Signature of Patient/Insured