PERIODONTAL Medicine | Surgical SPECIALISTS

GEORGE MANDELARIS | DDS, MS BRADLEY DEGROOT | DDS, MS
ALAN ROSENFELD | DDS, FACD *Emeritus*

www.PeriodontalMedicine.org

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs.	☐ Sr.
			☐ Dr. ☐ Miss	☐ Jr.

Street Address	City	State	Zip Code

Home Phone #	Work Phone #	Cell Phone #	Email Address
( ) -	( ) -	( ) -	

Birth Date	Age	Social Security Number	Marital Status	Sex
/ /			☐Single ☐Mar ☐Widow ☐Div	☐ M ☐ F

DENTAL INSURANCE INFORMATION

Occupation	Insured Employer
Insured Employer Address	

Please indicate insurance company	Address of insurance carrier	Phone number
		( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

MEDICAL INSURANCE INFORMATION

Occupation	Insured Employer
Insured Employer Address	

Please indicate insurance company	Address of insurance carrier	Phone number
		( ) -

Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

FAMILY PHYSICIAN INFORMATION

Primary Doctor's Name	Specialty	City	State	Zip Code	Phone Number:
Other Doctor's Name	**Specialty**	**City**	**State**	**Zip Code**	**Phone Number**

RESTORATIVE DENTIST INFORMATION

Doctors Name	Phone Number		
	( ) -		
Street Address	City	State	Zip Code

Whom may we thank for referring you? ☐ Doctor/Dentist ☐ Family/Friend ☐OTHER

ALLERGIES (LIST KNOWN ALLERGIES and REACTIONS TO DRUGS/MEDICATIONS)

☐ Penicillin ☐ Sulfa Drugs ☐ Clindamycin ☐ Local Anesthetic ☐ Barbiturates, sedatives ☐ Aspirin ☐ Iodine ☐ Latex ☐ Codeine

☐ NO KNOWN ALLERGIES ☐ NO KNOWN DRUG ALLERGIES

☐ Other known drug allergies, Please list:

☐ Other allergies (food, adhesives, tapes, Band-Aids etc) Please list:

Please list type of reaction for allergies indicated:

MEDICATIONS

(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)

MEDICATION	DOSE	MEDICATION	DOSE

Alcoholic beverage consumption: ☐ NO ☐ YES, Drinks per week

Tobacco Usage: ☐ NO ☐ YES, Pack(s)/day Duration years

Last medical examination:
HEIGHT WEIGHT

Women: Are you Pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

Do you have any problems associated with your menstral cycle? ☐ Yes ☐ No

Have you ever had sedation or general anesthesia in the past? ☐ Yes ☐ No If yes, List any complications?

CHIEF DENTAL COMPLAINT?

Are you experiencing pain at this time? ☐ No ☐ Yes, Location Duration of pain:

Please Indicate Previous Dental Treatment You Have Had:

☐ Surgery ☐ Orthodontics ☐ Treatment with an Oral Medicine specialist ☐ Endodontics (root canal therapy)

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	☐ Yes	☐ No	Sinus trouble or Hay fever	☐ Yes	☐ No
Artificial Joints: Date Placed	☐ Yes	☐ No	H.I.V. Positive or AIDS	☐ Yes	☐ No
Asthma: if yes, last attack:	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes: Type I, Type II or history of gestational (pregnancy)? Daily Blood Sugar: HgA1C: date:	☐ Yes	☐ No	Are you currently taking (or have ever taken) a bisphosphonate drug? (Actonel, Fosamax, etc.) Medication_____ Duration_____	☐ Yes	☐ No
Do you have a cardiac pacemaker?	☐ Yes	☐ No	Osteoporosis, Osteopenia If yes, T-score : ☐ >2.5 ☐ 1.5-2.5	☐ Yes	☐ No
Abnormal Bleeding, Anemia	☐ Yes	☐ No	Epilepsy, Neurological Disorders	☐ Yes	☐ No
Cardiovascular Disease: (heart trouble, heart attack, angina, coronary insufficiency/occlusion, high blood pressure, arteriosclerosis, stroke, valve replacement)	☐ Yes	☐ No	Diagnosed Sleep Apnea: Do you Use a CPAP or BIPAP machine?	☐ Yes ☐ Yes	☐ No ☐ No
Cancer: if yes, Type Treatment received: ☐ Radiation ☐ Chemotherapy ☐ Surgery	☐ Yes	☐ No	Stomach Problems ☐ Acid Reflux ☐ Heartburn ☐ GERD ☐ Ulcer	☐ Yes	☐ No
Liver Disease, Hepatitis, or jaundice	☐ Yes	☐ No	Psychological disorders/Mental Health Problems	☐ Yes	☐ No
Respiratory problems, emphysema, bronchitis, etc.	☐ Yes	☐ No	Tuberculosis or persistent cough	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No	Sexually transmitted diseases:	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Thyroid disorders: Hypo/ Hyper/Other:	☐ Yes	☐ No

Do you have any first degree relatives with a history of Diabetes? If Yes, what type? ☐ Mother ☐ Father ☐ Brother ☐ Sister Type

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors that I have made in the completion of this form.

X / /

Patient/Guardian Signature Date

It is sometimes necessary to consult with other health care related professionals and/or institutions in order to have the best information concerning your oral health. This form gives your authorization to request pertinent records about your past medical and dental history.

I hereby authorize any physician, dentist, or facility that has any record or knowledge of my health to give Periodontal Medicine & Surgical Specialists, LTD. any such information. A photographic/digital copy of this authorization shall be valid as original.

I understand that any balance over 60 days past due will be subject to a 1% per month finance charge and that I may be liable for any third party collection and/or attorney fees incurred in collecting the delinquent balance.

X / /

Patient/Guardian Signature Date

Patient Contact Information

Name_____ **Date**_____

I give my permission to be contacted on the phone numbers and/or email address listed below:

Home Phone _____ ☐ **Preferred Contact**

Messages may be left regarding: ☐ **Appointments** ☐ **Treatment** ☐ **Account Status**

Cell/Mobile Phone _____ ☐ **Preferred Contact**

Messages may be left regarding: ☐ **Appointments** ☐ **Treatment** ☐ **Account Status**

Work Phone _____ ☐ **Preferred Contact**

Messages may be left regarding: ☐ **Appointments** ☐ **Treatment** ☐ **Account Status**

Email _____ ☐ **Preferred Contact**

Messages may be sent regarding: ☐ **Appointments** ☐ **Treatment** ☐ **Account Status**

Information regarding appointments/treatment/account status may be discussed with:

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Pharmacy

Pharmacy Name: _____ **Address:** _____

Pharmacy Phone Number: _____

Emergency Contact

In the event of an emergency, please list the names and telephone numbers of two individuals you would like us to contact:

Emergency Contact (primary):

Name: _____**Relationship:**_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Emergency Contact (secondary):

Name: _____**Relationship:**_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Patient Signature_____ **Date** _____

Office use only

Reviewed and Witnessed by: _____ Position:_____ Date:_____

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www.PeriodontalMedicine.org

Phone | (630) 627-3930 Fax | (630) 627-2148

Notice of Facility Fees

The Oakbrook Terrace office of Periodontal Medicine & Surgical Specialists, LLC, is an Office-Based Surgery Center accredited by the Accreditation Association of Ambulatory Health Care (AAAHC).

It is important to note that you or your medical insurance carrier will receive two bills for CBCT imaging and/or surgical visits that combined represent the total cost of that visit (CBCT imaging and/or surgical therapy). One bill will be for the professional fees from the visit and the other bill will be for the facility fee of your visit. The facility fee is billed only to your medical insurance and will not be included in the global fee you are responsible for. These bills will be mailed separately and may not be received at the same time. Should you have any questions or need any assistance regarding your charges, please call the phone number listed on the bill.

In the event an insurer or payor makes payment directly to you for the facility fees charged by Periodontal Medicine & Surgical Specialists, LLC, you agree to remit such payment to us immediately.

Please talk to your medical insurance company about how they cover bills for accredited office-based surgery center clinics. Our Insurance Coordinator is also available to speak with you directly and answer any questions you may have.

Insured patients: Both of the bills that you receive are subject to the terms, conditions, and exclusions of your individual medical insurance policy. These bills may be subject to separate co-pays, deductibles, and/or coinsurance, as defined by your medical insurance policy. Please contact your medical insurance company for detailed information regarding specific coverage.

Oakbrook Terrace Office

Accredited by the ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

By signing below, I hereby acknowledge that I have read and understand the above notice.

Patient Name (Print): _____

Signature: _____ Date: _____

Office use only
Re viewed by (Initial): _____ Date: _____

ACKNOWLEDGMENT OF OUR NOTICE OF FINANCIAL POLICY AND INSURANCE LIABILITY PROCEDURES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Periodontal Medicine and Surgical Specialists, LTD. Policies: 1) Office Financial Policy and Procedures and 2) Notice of Insurance Liability Form. By signing below I am acknowledging that I have received or have had the opportunity to receive these documents and give my consent for treatment to be billed as stated within.

_____

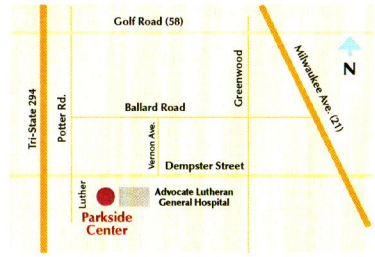
Patient Name (Print) Date

_____

Signature

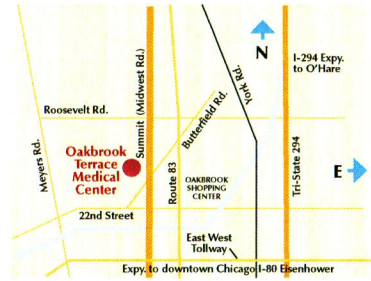
Personalized | Preventative | Predictable | Proven

THIS NOTICE DESCRIBES THE OFFICE BILLING AND FINANCIAL POLICIES FOR PERIODONTAL MEDICINE & SURGICAL SPECIALIISTS, LTD. PLEASE REVIEW IT CAREFULLY.



Park Ridge
Advocate Lutheran General Hospital
Parkside Center, Suite 250
1875 Dempster Street
Park Ridge, IL 60068

Phone: 847.698.1180
Fax: 847.698.1185



Oakbrook Terrace
Oakbrook Terrace Medical Center
Suite 205
1 S. 224 Summit Avenue
Oakbrook Terrace, IL 60181

Phone: 630.627.3930
Fax: 630.627.2148

Parking is available directly across from our Parkside Center office in Park Ridge, which is located on the west end of the Advocate Lutheran General Hospital parking lot. Valet parking is also available in front of the hospital.

Our Oakbrook Terrace office building has its own adjoining parking lot for patient use.

Oakbrook Terrace Medical Center
1s224 Summit Ave
Suite 205
Oakbrook Terrace, IL 60181
630.627.3930

Parkside Professional Building
1875 Dempster St.
Suite 250
Park Ridge, IL 60068
847.698.1180

PERIODONTAL Medicine | Surgical SPECIALISTS LTD

Office Financial Policy and Procedures

THIS NOTICE DESCRIBES THE OFFICE BILLING AND FINANCIAL POLICIES FOR PERIODONTAL MEDICINE & SURGICAL SPECIALIISTS, LTD. PLEASE REVIEW IT CAREFULLY.

Revised 2015
Effective as of March 1 2014

FINANCIAL POLICIES AND PROCEDURES

Revised 2015
Effective as of March 1, 2014

Treatment Fees

Fees for treatment are billed at the time of service. Our treatment coordinators will provide you with a personalized treatment plan which will outline the phases and associated costs.

Payments for treatment rendered are due at the time of service.

Payment for custom appliances, surgical guides, biologics and/or implantable devices may be requested prior to ordering them for your treatment. Many items are ordered for your Individualized therapy and may not be transferred for use on another patient. Refunds will not be extended in the event treatment is delayed or cancelled.

In order to continue to provide care to our patients at the highest level, the minimum payment required at the time of surgery is 50% of the total fee for that particular procedure/ phase.

Self Pay Accounts

Treatment fees that exceed $1000 and which are paid in full at time of treatment will be extended a 5% courtesy discount. Surgical supplies, regenerative materials, biologics and custom appliances are not discounted.

Interest free payment plans are also available in office and extended up to 2 months following the start of each phase. There is a 1% interest charge on any balance remaining after 60 days. For your convenience we accept Visa, MasterCard, American Express and Discover Credit Cards. If you need additional assistance, our office may provide you with a third party service for alternative payment options.

Insurance Networks and Contracts

We take care of our patients based on their treatment needs and **not** based on the limitations of dental insurance. There is a great deal of confusion about dental insurance. To be clear, we do not work for any insurance company or for any PPO or HMO. We work for you. Our treatment recommendations are based solely on what will give you the best outcome in consideration of your treatment goals and preferences. In general, a dental insurance company will base treatment allowances based on what is best for their profit margins.

With this in mind, we are a fee for service office. This means that we do not let an insurance company dictate when, where, or how to treat a patient. Fees for our services are the responsibility of the patient. However, we will do everything possible to maximize your insurance benefits including filing to your dental and medical insurance carriers. Their reimbursement to you is based on your plan that has been negotiated between your employer and the insurance company.

There are two methods commonly used by dental insurance companies to limit your reimbursement. The first is the payment schedule, which limits the amount covered for any particular procedure. Payment schedules are specific to the carrier, plan details, and employer selection of your plan.

The second, and most restricting, limitation to benefits is the yearly maximum payment the dental insurance company will reimburse. Regardless of the procedure coverage, most dental insurance companies will cap payment between $1000 and $2000 per calender year. Therefore, if the insurance company's scheduled reimbursement for a $3000 procedure was $2400, they would still only pay up to their yearly maximum of $2000.

While we are not directly involved with any insurance company, we will do all we can to help you derive the maximum benefit from your insurance plan.

Payments, Insurance and Discounts

Payment is required in full for new patient consultations, dental/periodontal cleanings, and CBCT imaging at the time of service. Claim submission will still be provided as a courtesy to our patients.

For more extensive treatment we will submit a pre-treatment estimate to your insurance company, when requested, to determine what reimbursement is available for anticipated services. After that treatment is completed, our office will then send in a final insurance claim for you.

Discounts applied to fees for treatment must be reflected to your insurance carrier. The total amount charged to you is the allowable amount for submission to your insurance provider.

For patients who retain a zero balance, payment will be requested to be assigned directly to you from your insurance company. Any benefit received by our practice on a settled account will be assigned from Periodontal Medicine & Surgical Specialists to the patient.

For patients retaining a balance or payment arrangement with our office, assignment of benefits will remain to our office. Payment received from your plan benefit will reduce your responsibility of your payment arrangement.

In the event a patient who retains a balance receives payment from their insurance company, the patient shall immediately remit such amount to the practice.

Any delinquent balance over 60 days past due will be subject to a 1% per month finance charge and subject to any third party collection and/or attorney fees incurred in collecting the delinquent balance.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Periodontal Medicine and Surgical Specialists, LTD. Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Signature

restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint at:

office@periodontalmedicine.org

PERIODONTAL Medicine | Surgical SPECIALISTS

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

You will be asked to sign an "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

- **Oakbrook Terrace Medical Center**
  1 S. 224 Summit Ave., Suite 205 Oakbrook Terrace, IL 60181
- **Lincoln Park**
  1009 W. Webster Ave., Chicago, IL 60614
- **Advocate Lutheran General Hospital**
  1875 Dempster St., Suite 250 Parkside Center Park Ridge, IL 60068

Main | 630.627.3930 Fax | 630.627.2148

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Revised 2017
Effec ve as of April 14, 2003

PERIODONTAL Medicine | Surgical SPECIALISTS

Omnibus Notice of Privacy Practices

Revised 2017
Effective as of
April 14, 2003

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the our practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations: We may use or disclose, asneeded, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of dental students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental school students that observe patients at our office. IWe may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested