PATIENT	#		

PAHENI INFURMATION	The state of the s
(PLEASE PRINT)	DATE

ADDRESS	NAMEFIRST MI LAST	BIRTHDATE		HOME PHONE	*
E-MAIL				STATE/	ZIP/
CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATEI PATIENT'S OR PARENTIGUARDIAN'S EMPLOYER  WORK PHONE BUSINESS ADDRESS  CITY  PROV. PRO					
PAILEN'S OR PARENTIGUARDIAN'S EMPLOYER  BUSINESS ADDRESS  CITY  PROV.  P	E-MAIL	CELL PHONE _			
BUSINESS ADDRESS CITY PROV. 2PC.  STATE/ PROV. WHOM MAY WE THANK FOR REFERRING YOU? PERSON TO CONTACT IN CASE OF AN EMERGENCY PHONE  RESPONSIBLE PARTY  NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT TO PATIENT PROV.  BIRTHDATE PROV. PR	PATIENT'S OR				
PARENTIGUARDIAN'S NAME	BUSINESS ADDRESS	CITY		STATE/	ZIP/
IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE  WHOM MAY WE THANK FOR REFERRING YOU?  PERSON TO CONTACT IN CASE OF AN EMERGENCY  NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT  ADDRESS  E-MAIL  CELL PHONE  FINANCIAL INSTITUTION  BIRTHDATE  IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  INSURANCE INFORMATION  RELATIONSHIP  TO PATIENT  BIRTHDATE  SS #/SIN  DATE EMPLOYER  ADDRESS OF EMPLOYER  ADDRESS OF EMPLOYER  CITY  PROV.  PROV.  DOV.  P.C.  INSURANCE COMPANY  GROUP #  UNION OR LOCAL #  STATE/ STATE/ ZIP/ PROV.  PROV.  P.C.  DO YOU HAVE ANY ADDITIONAL INSURANCE?  NAME OF INSURED  SS #/SIN  DATE EMPLOYED  MAX. ANNUAL BENEFIT?  NAME OF INSURED  RELATIONSHIP  TO PATIENT  UNION OR LOCAL #  STATE/ ZIP/ PROV.  PROV.  P.C.  DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO  IF YES, COMPLETE THE FOLLOWING:  RELATIONSHIP  TO PATIENT  DATE EMPLOYED  MAX. ANNUAL BENEFIT?  NAME OF INSURED  RELATIONSHIP  TO PATIENT  DATE EMPLOYER  WORK PHONE  RELATIONSHIP  TO PATIENT  DATE EMPLOYER  WORK PHONE  STATE/ ZIP/ PROV.  PROV.  P.C.  NAME OF EMPLOYER  WORK PHONE  STATE/ ZIP/ PROV.  PROV	SPOUSE OR PARENT/GUARDIAN'S NAME E	MPLOYER		WORK PHONE	1.0
RESPONSIBLE PARTY  RELATIONSHIP TO PATIENT  ADDRESS HOME PHONE  E-MAIL CELL PHONE  BIRTHDATE FINANCIAL INSTITUTION  WORK PHONE  BIRTHDATE SS #/SIN DATE EMPLOYER  ADDRESS OF EMPLOYER CITY PROV. P.C.  INSURANCE COMPANY GROUP # UNION OR LOCAL #  INSURANCE OF EMPLOYER HOW MUCH HAVE YOU USED?  NAME OF INSURED S #/SIN DATE EMPLOYED HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:  RELATIONSHIP TO PATIENT  STATE/ ZIP/ PROV. P.C.  PR	IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _			CITY	STATE/ PROV
RESPONSIBLE PARTY  NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT	WHOM MAY WE THANK FOR REFERRING YOU?				
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT					
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT  ADDRESS	RESPONSIBLE PARTY				
ADDRESS	NAME OF DEDCON DESDONSIDLE FOR THIS ACCOUNT				
E-MAIL					
DRIVER'S LICENSE #BIRTHDATEFINANCIAL INSTITUTION  EMPLOYERWORK PHONE  IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YESNO  INSURANCE INFORMATION  RELATIONSHIP TO PATIENT  DATE EMPLOYED NAME OF INSURED WORK PHONE					
EMPLOYER					
INSURANCE INFORMATION    NAME OF INSURED					
INSURANCE INFORMATION  RELATIONSHIP TO PATIENT  BIRTHDATE  SS #/SIN  DATE EMPLOYED  NAME OF EMPLOYER  ADDRESS OF EMPLOYER  CITY  PROV. P.C.  INSURANCE COMPANY  GROUP # UNION OR LOCAL # STATE/ STATE/ ZIP/ PROV. P.C.  HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED?  MAX. ANNUAL BENEFIT?  DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO  IF YES, COMPLETE THE FOLLOWING:  RELATIONSHIP TO PATIENT  BIRTHDATE  SS #/SIN  DATE EMPLOYED  NAME OF EMPLOYER  ADDRESS OF EMPLOYER  LITY  WORK PHONE  STATE/ ZIP/ PROV. P.C.  INSURANCE COMPANY  GROUP # UNION OR LOCAL #	A 8				
RELATIONSHIP TO PATIENT  BIRTHDATE SS #/SIN DATE EMPLOYED  NAME OF EMPLOYER WORK PHONE ADDRESS OF EMPLOYER GROUP # UNION OR LOCAL # STATE/ ZIP/ PROV. P.C.  INSURANCE COMPANY GROUP # UNION OR LOCAL # STATE/ ZIP/ PROV. P.C.  HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED? MAX. ANNUAL BENEFIT?  DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:  NAME OF INSURED RELATIONSHIP TO PATIENT  BIRTHDATE SS #/SIN DATE EMPLOYED  ADDRESS OF EMPLOYER ORK PHONE  ADDRESS OF EMPLOYER ORK PHONE  INSURANCE COMPANY  RELATIONSHIP TO PATIENT  STATE/ ZIP/ PROV. P.C.  STATE/ ZIP/ PROV. P.C.  INSURANCE COMPANY  GROUP # UNION OR LOCAL #	IS THIS TERSON CORRENTED A PAILENT IN COR OFFICE.				
NAME OF INSURED SS #/SIN DATE EMPLOYED  NAME OF EMPLOYER WORK PHONE WORK PHONE STATE/ ZIP/ PROV. P.C PROV. P.C UNION OR LOCAL # STATE/ ZIP/ PROV. P.C	INSURANCE INFORMATION				
BIRTHDATE	NAME OF INSURED				
NAME OF EMPLOYER					
ADDRESS OF EMPLOYER	NAME OF EMPLOYED	WORK	DUONE		
INSURANCE COMPANY GROUP # UNION OR LOCAL # STATE/ ZIP/ PROV. P.C PROV. P.C PROV. P.C PROV. P.C DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:  NAME OF INSURED SS #/SIN DATE EMPLOYED PATIENT DATE EMPLOYED WORK PHONE ADDRESS OF EMPLOYER WORK PHONE UNION OR LOCAL #	ADDRESS OF EMPLOYER	CITY	THORE _	STATE/ Z	IIP/
INS. CO. ADDRESS					
HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED? MAX. ANNUAL BENEFIT?  DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:  RELATIONSHIP TO PATIENT  BIRTHDATE SS #/SIN DATE EMPLOYED  NAME OF EMPLOYER WORK PHONE ADDRESS OF EMPLOYER CITY PROV P.C  INSURANCE COMPANY GROUP # UNION OR LOCAL #	INS. CO. ADDRESS	CITY		STATE/ Z PROV F	ZIP/
NAME OF INSURED SS #/SIN DATE EMPLOYED  NAME OF EMPLOYER WORK PHONE STATE/ ZIP/ PROV P.C  INSURANCE COMPANY GROUP # UNION OR LOCAL #					
NAME OF INSURED	DO YOU HAVE ANY ADDITIONAL INSURANCE?	YES NO	IF YES,	COMPLETE THE	FOLLOWING:
BIRTHDATESS #/SINDATE EMPLOYED  NAME OF EMPLOYERWORK PHONE  ADDRESS OF EMPLOYERCITYPROVP.C  INSURANCE COMPANY GROUP # UNION OR LOCAL #	NAME OF INSURED	,			
NAME OF EMPLOYER WORK PHONE STATE/ ZIP/ ADDRESS OF EMPLOYER CITY PROV P.C  INSURANCE COMPANY GROUP # UNION OR LOCAL #					
ADDRESS OF EMPLOYER CITY STATE/ PROV P.C  INSURANCE COMPANY GROUP # UNION OR LOCAL #			DUIONE		
INSURANCE COMPANY GROUP # UNION OR LOCAL #	ADDRESS OF EMPLOYER	CITY		STATE/ Z PROV F	ZIP/ P.C
INS. CO. ADDRESSCITY STATE/ ZIP/ PROV. P.C.	INSURANCE COMPANY	GROUP #		UNION OR LOCAL	#
	INS. CO. ADDRESS	CITY		STATE/ Z PROV F	ZIP/ P.C
HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED?MAX. ANNUAL BENEFIT?					

**SIGNATURE** 

		PATIE	NT MI	EDI	CALI	HISTO	RY				
PH	YSICIAN	OFFICE P	PHONE _ NO				DATE	OF LAST E	XAM		
1.	ARE YOU UNDER MEDICAL TREATMENT NOW?			8.	ARE YO		GIC TO OR HAV	E YOU HAD A	ANY REACTIONS TO THE FOL YES NO	LOWING	
2.	HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?					(E.G. N	IOVOCAINE)		ARBITURATES 🔲 🔲 ASI		
3.	ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?					ANTIBI				HER	
	IF YES, WHAT MEDICATION(S) ARE YOU TAKING?_			- 9			DRUGS  A PERSISTEN		ODINE YES	NO	
4.	HAVE YOU EVER TAKEN FEN-PHEN/REDUX?				CLEA	RING NO	T ASSOCIATED	D WITH A KN	NOWN		
5.	DO YOU USE TOBACCO?			10.		EN ONLY		S THINK YOU	U MAY BE PREGNANT?		
6.	DO YOU USE ALCOHOL, COCAINE OR OTHER DRUC	SS? 🔲			B) A	RE YOU	NURSING?		ō		
7.	ARE YOU WEARING CONTACT LENSES?				C) A	RE YOU	TAKING BIRTH	CONTROL	PILLS?		
11.	DO YOU HAVE OR HAVE YOU HAD ANY OF THE FO	OLLOWING	?			***************************************			COMME	NTS	
	YES NO YES NO				YE	S NO				W. E. W. E.	
	KIDNEY DISEASES   HEPATI	AC PACEM MURMUR A ENTLY TIRE A (SEMA ER ITIS REPLACEM TIS / JAUNI	ENT OR DICE MITTED I	DISE	ANT C		HEST PAINS ASILY WINDED IROKE AY FEVER / ALL UBERCULOSIS ADIATION THEI LAUCOMA ECENT WEIGHT VER DISEASE EART TROUBLE ESPIRATORY PI THER	RAPY I LOSS	SIGNATURE OF DENTIST		DATE
PATIENT DENTAL HISTORY											
0			YI	ES	NO					YES	NO
	<ol> <li>DO YOUR GUMS BLEED WHILE BRUSHING OR FI</li> <li>ARE YOUR TEETH SENSITIVE TO HOT OR COLD LI</li> <li>ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR</li> </ol>	QUIDS/FO				9. 10.	DO YOU CLEM DO YOU BITE	NCH OR GRI YOUR LIPS	HEADACHES? IND YOUR TEETH? OR CHEEKS FREQUENTLY?		
	<ul><li>4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?</li><li>5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEA</li></ul>	AR YOUR M	OUTH?	_		11.	IN THE PAST?		Y DIFFICULT EXTRACTIONS		
	6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJUR			J		12.	HAVE YOU HA	D ANY ORTI	HODONTIC WORK?		
	7. HAVE YOU EVER EXPERIENCED ANY OF THE FOL PROBLEMS IN YOUR JAW?	LOWING	r				FOLLOWING	EXTRACTIO			
	A) CLICKING? B) PAIN (JOINT, EAR, SIDE OF FACE)' C) DIFFICULTY IN OPENING OR CLO		Ĺ				CORRECT ME	ETHOD OF B	TRUCTION ON THE RUSHING YOUR TEETH?		
_	D) DIFFICULTY IN CHEWING?			j		15.	CARE OF YOU		TRUCTIONS ON THE		
0	I CERTIFY THAT I HAVE READ AN	ND UNDERSTA	ND THE AE	BOVE I	NFORMATI	ION. TO THE	E BEST OF MY KNO	OWLEDGE, THE	ABOVE QUESTIONS HAVE BEEN A	CCURATELY	ANSWERED.

**SIGNATURE** 

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

PATIENT, PARENT OR GUARDIAN

DATE

## **HIPAA FORM**

Patient Name:		
	Name of the second seco	4110
D.O.B:		

While providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office (or from our website).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also s that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions

If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from **Dr. Tambornini** 

Signature	Date
If signing as a personal representative of the patient and the source of authority	f the patient, describe the relationship to to sign this form:
Relationship to Patient	Print Name
Source of Authority:	

DR. GINA L. TAMBORNINI, D.D.S. 1640 N. WELLS ST, SUITE 205 CHICAGO, IL 60614-60606 TELEPHONE (312)642-4218

EMAIL: PANDTDDS@GMAIL.COM

# TAMBORNINI DENTAL

Payment for services, including deductibles and copayments, are <u>due at the time of the service</u> unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards.

**Tambornini Dental** accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We **cannot** guarantee that any coverage estimated by your plan will be paid once a claim is filed.

To maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but **not all** dental care costs, and not all services are covered by your plan.

You are responsible for payment of all services regardless of the payable benefit.

Checks that are returned to our office from your financial institution are subject to a \$\_\_20\_\_returned check fee\*. This fee covers the processing fees that are charged to our office.

Please indicate your **understanding** and **acceptance** of these financial policies by signing below.

Patient	
name	Date
Patient	
signature	Date

## CREDIT CARD ON FILE POLICY

At Dr. Tambornini, D. D. S., we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which **you are liable**.

### We will automatically charge your credit card if the balance is NOT paid after 30 days.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid, and posted to the account.

l authorize Tambornini, D. D. S. to charge the portion of my bill that is my financial responsibility to the

following credit or debit card: □ Amex □ Visa □ Mastercard □ Discover Credit Card Number Expiration Date \_\_\_\_/\_\_\_/ Security Code Cardholder Name \_\_\_\_\_ Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ I (we), the undersigned, authorize and request Tambornini, D. D. S. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Tambornini, D. D. S. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to [practice name] in writing and the account must be in good standing. Patient Name (Print): Patient Signature: \_\_\_\_\_\_ Date: \_\_\_/ \_\_\_/