

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____

FIRST MI LAST

ADDRESS _____ CITY _____ STATE/ZIP/PROV. P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/ZIP/PROV. P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ 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 _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/ZIP/PROV. P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ 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 _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/ZIP/PROV. P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/ZIP/PROV. P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

HIPAA FORM

Patient Name: _____

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, describe the relationship to the patient and the source of authority 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 **due at the time of the service** 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.

I 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 _____

Signature _____

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: ____ / ____ / ____