Welcome

We are pleased to welcome you to our practice. Please, take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name ______________________________ Soc. Sec. # ______________
Last Name *First Name* *Initial*
Address ______________________________
City ______________ State ________ Zip ________ Home Phone ______________
Cell Phone ______________ Email ______________
Sex ☐ M ☐ F Age ________ Birthdate ________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed by ______________ Occupation ______________
Business Address ______________ Business Phone ______________
Business Email ______________
Whom may we thank for referring you? ______________
Notify in case of emergency ______________ Home Phone ______________
Cell Phone ______________ Business Phone ______________
Email ______________
Person Responsible for Account: ______________

Primary Insurance Subscriber

Name: ______________________________ Soc. Sec. # ______________
Last Name *First Name* *Initial*
Birthday ______________
Occupation ______________
Employee ______________
Insurance Plan ______________

Dental History

What would you like us to do today? ______________
Are you in any dental discomfort today? ______________
Former Dentist ______________
Date of last dental care ______________

Check (✓) yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth

How often do you brush? ______________
How do you feel about the appearance of your teeth? ______________
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N
Other information about your dental health or previous treatment: ______________

Please complete both sides

Medical History

Physician's name ____ Phone ________________
Date of last visit ________________________________ Have you had any serious illnesses or operations? ☐ Y ☐ N
If yes, describe ____
Are you currently under physician care? ☐ Y ☐ N If yes, describe ____
Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates ____________________________
Have you ever taken Fen-Phen/Redux ☐ Y ☐ N
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva ☐ Y ☐ N
Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or no whether you have had any of the following:

☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cortisone treatments	☐ Y ☐ N Hepatitis	☐ Y ☐ N Shingles
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough, persistent	☐ Y ☐ N High blood pressure	☐ Y ☐ N Shortness of breath
☐ Y ☐ N Anemia	☐ Y ☐ N Cough up blood	☐ Y ☐ N Jaw pain	☐ Y ☐ N Skin rash
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Diabetes	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	☐ Y ☐ N Stroke
☐ Y ☐ N Artificial joints	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies (**latex**, wool, metal, chemicals)	☐ Y ☐ N Surgical implant
☐ Y ☐ N Asthma	☐ Y ☐ N Food allergies	☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Glaucoma	☐ Y ☐ N Nervous problems	☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Back problems	☐ Y ☐ N Headaches	☐ Y ☐ N Pacemaker/Heart surgery	☐ Y ☐ N Tobacco habit
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart murmur	☐ Y ☐ N Psychiatric care	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Cancer	☐ Y ☐ N Heart problems	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemical dependency	Describe ______________	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Hemophilia/ Abnormal bleeding	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Venereal disease
☐ Y ☐ N Circulatory problems	☐ Y ☐ N Herpes	☐ Y ☐ N Rheumatic/Scarlet fever	

Is patient currently taking any medications? If yes, list all:
____
____

Does patient have drug allergies? If yes, list all:
____
____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
Signature:____ Date:____________________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Facts About Dental Insurance You Should Know

Dental Insurance and Patient Responsibility

*Many dental plans are based on a contract between an employer and the insurance company or an individual and the insurance company. They agree on the amount that the plan pays and what procedures are covered. If you have a dental care need that is not covered by your plan, you are responsible for that cost. Because your dental office is not part of that contract with the insurance company, any information we have about a dental plan's benefits comes from the general information the insurance company has provided about the plan (through a web portal, speaking to an insurance representative, or by way of a limited, faxed benefit summary). **X**__________

*A dental plan may not cover treatment for conditions that existed before you enrolled in that specific plan (such as treatment in progress). Even if your plan does not pay for certain procedures, you my still need that treatment to keep your mouth healthy. Your dentist will base your treatment plan on what you need, which won't always align to what your insurance will pay for. **X**_________

*Dental insurance rarely covers 100% of the services provided. Check your plan(s) for details regarding your dental benefit. **X**_________

*When we recommend a treatment plan, our team will be happy to provide you with an estimate of what your insurance will likely pay for your procedures. Although we cannot guarantee the amount of insurance payment, we will always submit claims to your insurance company as a courtesy. We will estimate your portion based on the general information that your insurance company provides for that plan. Just like with your medical coverage, you are ultimately responsible for any uncovered portion of the fee for treatment. **X**_________

By signing and initialing below, I acknowledge that I am solely responsible for my account at Morton Family Dental of Berwyn. This Pertains to any and all treatment not covered by my insurance company.

Patient Signature: ________________________________

Date: _________________________________

X______ I understand that Morton Family Dental of Berwyn will bill my account for treatment not paid by my insurance company within 90 days of the treatment service date.

X_______ I understand that is my responsibility to know my insurance plan benefit coverage and details.

Dr. Serrano, Dr. Vafa, Dr. Toledano and staff appreciate all of our valued patients and do our very best to provide you with quality dental care and a good overall dental experience.

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill and keeping your scheduled appointments is considered part of your treatment program. Your clear understanding of the Financial Policy and Cancellation Policy is important to our professional relationship. Please talk to your office team if you have any questions.

Financial Policy

• Full Payment is due at the time of service.

Our office accepts assignment of insurance benefits. We verify eligibility for all insurances; if your insurance company is expected to pay a portion of your bill, we will wait for that portion from them. It is your responsibility to pay co-pays, deductibles and any amount not expected from your insurance at the time treatment is provided. If you do not have insurance, or if our office does not accept assignment from your insurance company, then payment is due in full at the time of treatment. If the balance is not paid at the time of service, for whatever reason, it is agreed that our office is extending credit to you as a courtesy. If credit is extended, you authorize our office and/or agents to access your consumer credit report.

If your insurance company has not paid the full balance within 60 days, the balance of your account will become your responsibility. Please be aware that some and perhaps all of the services provided maybe "non-covered" services and not considered necessary under your dental insurance. An example of such a service is "tooth colored" composite fillings. Many insurances only pay for metal fillings; in such a case, you will be responsible for the difference in cost.

In addition, your insurance company may pay based on fees considered "usual and customary" that differ from ours. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our patients. You are responsible for payment in full regardless of your insurance company's arbitrary determination of "usual and customary" rates.

Please remember that insurance is a contract between you and your insurance company. Our office is not part of this contract. **You are responsible for the timely payment of your account.** In the event that your account is sent to collections, you will be responsible for all costs of collection and reasonable attorney's fees.

Our office accepts Cash, Apple Pay, Visa, MasterCard, American Express, Discover, and Care Credit.

Appointments and Cancellation Policy

• 48-hour notice is required to change a scheduled appointment. A $100 fee will be applied for all appointments cancelled or failed without a 48-hour notice.

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 48 hours' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.
*****Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

If you fail to confirm your appointments, our office reserves the right to cancel your appointment or those of your family members. After 2 missed appointments we will no longer be able to reserve appointment time for you in advance.

Thank you for understanding our Financial and our Cancellation Policies. Please let us know if you have any questions or concerns.

I have read the above and fully understand the terms thereof.

____
Patient's Name:

____ ________________________________
Patient's Signature (Parent or Guardian if patient is minor): Date:

Morton Family Dental of Berwyn
6931 Cermak Road
Berwyn, IL 60402
(708) 484-6847 Office
www.MortonFamilyDentalof Berwyn.com

Thank you for choosing our office for your family's dental needs. We do our absolute best to help you understand and estimate your insurance benefits. As a courtesy, our office will verify your insurance with your insurance carrier as long as you provide us with your up-to-date and correct insurance information no less than 1 business day before your appointment. In addition, we will file your dental claim with your insurance carrier. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment. Due to the thousands of insurance plans we ask that you know your benefits for it would be impossible for us to know them all. Each insurance plan is unique in what services they will allow. Please be aware that your dental insurance plan is a contract between you, your employer, and the insurance company. It is your responsibility to know the benefits, limitations and exclusions of your dental plan. If you are unhappy with its specific coverage, please contact your Human Resources Department.

Only your employer can adjust benefits or change policies. We are not responsible, nor can we guarantee, how your insurance caries will pay on a claim. Once the insurance carrier paid their portion, the remaining balance will become your responsibility.

Please note that treatment plans change on occasion during the course of treatment because conditions can worsen or improve and can therefore change your financial responsibility in either direction.

Your deductible and/or copay is due at the time services are rendered. Because your insurance company makes no guarantee of payment, we cannot always guarantee your exact insurance coverage. Therefore, you may receive a statement with an additional balance after your insurance has met their obligation. We ask that your portion be paid at the time the service or within 15 days of receiving such statement. We are always available to answer your questions and/or assist you in any way we can.

I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office and that it is my responsibility to notify the office of any changes in my insurance.

Patients name:____ Date:____________

Signature:____

Email: mortondentaberwyn@gmail.com

Website: www.dentistryberwyn.com

Phone Number: 708.484.6847

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include to share information with other providers or specialist involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications or protected health information from us by alternative means or at alternative locations.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 24, 2016, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You may recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Morton Family Dental of Berwyn
6931 Cermak Road
Berwyn, IL 60402
(708) 484-6847 Office
(844) 315-7379 Fax
Email: mortondentalberwyn@gmail.com

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

MORTON FAMILY DENTAL OF BERWYN
6931 Cermak Road
Berwyn, IL 60402

I, ____, hereby acknowledge that I have received and/or reviewed a

(Print Patient Name)

copy of **Morton Family Dental of Berwyn's** *HIPPA Notice of Privacy Practices.*

I understand that **Morton Family Dental of Berwyn's** *HIPPA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Morton Family Dental of Berwyn's** revised *HIPPA Notice of Privacy Practices* upon request. I understand that, if I have questions about **Morton Family Dental of Morton's** *HIPPA Notice of Privacy Practices,* I may contact:

Morton Family Dental of Berwyn
6931 Cermak Road
Berwyn, IL 60402
(708) 484-6847 Office
(844) 315-7379 Fax

I understand that it is my right to refuse to sign this Acknowledgement should I choose, and that **Morton Family Dental of Berwyn** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Morton Family Dental of Berwyn's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Morton Family Dental of Berwyn noted above, for assistance.

______________________________ ______________________________
Patient's Name: Date:

______________________________ ______________________________
Signature of Patient or Parent/Guardian: Print Name of Parent/Guardian

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FOR OFFICE USE ONLY

Morton Family Dental of Berwyn made a good-faith effort to obtain Acknowledgement from the patient noted above, receipt of its HIPPA Notice of Privacy Practices. In spite of these efforts, **Morton Family Dental of Berwyn** was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on __________________ (date)
- ☐ Communication barriers prohibited us from obtaining a signed Acknowledgement
- ☐ An emergency prohibited us from obtaining a signed Acknowledgement
- ☐ Other (describe): ____

How did you hear about your office? (Select **ALL** that apply)

¿Como se enteró de nuestra oficina? (Seleccione **TODAS** las que correspondan)

- ☐ Google
- ☐ Facebook
- ☐ Yelp
- ☐ Office website: www.dentistinberwyn.com
- ☐ School Event
- ☐ Back to School event (Unity School)
- ☐ Nuestras Raices Event
- ☐ Insurance company: ______________________________
- ☐ El Dia Newspaper
- ☐ Drove by
- ☐ Morton School
- ☐ Berwyn Magazine
- ☐ Family/Friend: ______________________________
- ☐ Dr.Serrano/Dr.Vafa/ Dr.Toledano/Office Staff: ______________________________

CREDIT CARD ON FILE AUTHORIZATION

We are moving towards the direction of paperless, touch free transactions in our office. We want your check out process/experience with us to be completed with ease. That being said, providing a credit/debit card on file will save you a stop after your visit with our outstanding doctors. Having a card on file will also help with future payments and with reserving appointments.

This form must be completed before your next appointment.

Information is to be completed by the card holder:

Card Holder Name:_________________________________ **Billing Zip Code**:________________

Card Number:____

Card Type:____________________ **Expiration Date**:_________________ **CVV**:______________

Email for Receipts:____

I authorize Morton Family Dental of Berwyn (Dr. Sara Vafa, Dr. Mario Serrano, Dr. Lawrence Toledano) to charge the above credit/debit card account for any payments owed to my account for services rendered at their office. I agree to update any information regarding this account. I understand that I have provided my card information and that the above information is complete and correct to the best of my knowledge.

Your Credit/Debit Card can be charged for the following:

-**Estimated cost of treatment** - After explaining the estimated cost you to you and along with approval, your card will be charged for the purposed plan and procedure.

-**Any balance that is left after insurance payment** - We collect the estimated payment from you at the time of service, but any remaining balance will be charged to the credit card on file. (For

example, we may estimate that your insurance pays $150.00 for a procedure, but for many different reasons, the insurance may pay only $125.00. In this case we would charge your card on file for the difference of $25.00)

-**Broken Appointment Fees** - $100.00 Fee per hour/per broken appointment. A broken appointment is considered any of the following:

-**No Call/No Shows**

-**Canceling Within Our 48 Hour Time Frame**

-**Rescheduling Within Our 48 Hour Time Frame**

(Please take into consideration that when a patient does not show to their appointment, staff must still be paid during that time that is now lost. Canceling or rescheduling before 48 hours allows us time to fill that spot with another patient that may be in pain or may have a tight schedule.)

Note: Regarding our 48 hour notice for cancelations or rescheduling – in order to cancel/reschedule an appointment without being charged a broken appointment fee, we ask our patients to call/text/email us on days that we are open – during business hours. Appointments MAY NOT be cancelled on Saturdays or Sundays. (We are only open 3 Saturdays a month, we may not be in office every Saturday) For example, if you have an appointment Monday at 10AM and need to reschedule that appointment; you must contact us before 10AM on Friday.

We hope that we never have to charge any of our patients for broken appointments and hope that by following these rules we can avoid any charge. We appreciate your help and understanding and of course thank you for choosing Morton Family Dental of Berwyn.

Patient/Guardian Name:____ **Date:**___________________

Patient/Guardian Signature:____