CORLEY FAMILY DENTAL

MODERN • COMPASSIONATE • EXCELLENCE

Dr. Natalie A. Corley & Dr. Chad A. Corley
217-330-6217 www.corleyfamilydental.com

Thank you for choosing **Corley Family Dental** to care for your oral health. We want you to feel **relaxed**, **comfortable**, and **well informed** during your visit. Our goal is to educate you on your oral health and promote overall wellness through healthy eating habits and preventative oral hygiene. We understand visits can be overwhelming and encourage you to call with any questions you may have regarding treatment. **Sincerely**, Dr. Natalie & Chad Corley & Team

Patient Information (CONFIDENTIAL)

Today's Date _____

Name _____ Preferred Name _____
Birthdate _____ SSN _____ Gender : Male ___ Female ___
Address _____ City/State _____ Zip _____
Home ph# _____ Work ph# _____ Cell Ph# _____
E-mail _____ Preferred contact method: _____
Check appropriate box ___Child ___Single ___Married ___Divorced ___ Widowed
If over 19, is patient Full Time College Student? ___Yes ___No
If yes, Name of School _____ City, State _____
Patient or Parent/Guardian's Employer _____
Business Address _____ Work Ph# _____
City, State, Zip _____
Spouses or Parent/Guardian's Name _____
Employer _____ Work Ph# _____
City, State, Zip _____
Person to contact in case of an emergency? _____
How did you hear about our practice? _____

Responsible Party

Name of person responsible for account (if different than self) _____
Address _____ City/State _____ Zip _____
Phone# _____ SSN _____Dob _____
Employer _____ Work Ph# _____
Marital Status_____ Is this person currently a patient in our office ___Yes ___No

Dental Insurance Information

Member ID# _____
Insured Employee _____ Birthdate _____ SSN _____
Employer _____ Phone _____
Insurance Company_____ Group# _____ Phone _____
Address _____ City/State _____ Zip _____

Insurance claims are submitted daily as a courtesy to our patients. We do ask that you pay your estimated co-payment & deductible at the time of service. Thank you for your cooperation.

Signature _____ Date _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ___Yes ___No IF YES, COMPLETE BELOW
Insured Employee _____ Birthdate _____ SSN _____
Employer _____ Phone _____
Insurance Company_____ Group# _____ Member ID#_____
Address _____ City/State _____ Zip _____

Thank you!

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed. Please read it carefully.
The privacy of your health information is important to us.

Corley Family Dental • 160 W. McKinley Ave. • Decatur, IL 62526

OUR LEGAL DUTY

Under the Health Insurance Portability Act of 1996, we are required by applicable federal and state laws to maintain the privacy of your health inform. We are also required to give you this Notice about our privacy practices. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 15, 2003 and will remain in effect until we replace it.

We have the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

USES AND DISCLOSURES OF HEATLH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may use or disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in Care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of you incapacitated or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your consent.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we are reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may use or disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with your appointment reminders (such as voice mail, messages, postcards or letters).

ACKOWLEDGEMENT of RECEIVING
NOTICE of PRIVACY PRACTICES

Corley Family Dental
160 W McKinley Ave.
Decatur, IL 62526

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

I give permission to: Corley Family Dental to share my health information with:

_____

so that this person or entity may assist me with my health care issues.

Corley Family Dental may share my health information until I revoke the authorization.

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature acknowledging receipt of our Notice of Privacy Practices, but was unable to do, also as documented below:

Date:	Initials:	Reason:

Corley Family Dental Office Policies

Thank you for choosing Corley Family Dental as your dental provider. We pride ourselves on providing all patients with excellent dental services. Billing costs have risen enormously and we ask your help in controlling these costs. To keep you informed of our current financial policies, please read the following, initial each policy, and sign at the bottom. Let us know if you would like a copy made for your future reference.

Office Hours

Mon 7am-7pm; Tues & Wed 7am-5pm; Thurs 7am-4pm; Fri 7am-4pm; Sat 7am-noon (2x month)

Copays, Deductibles and Non-Covered Services: _____INITIAL

All estimated co-pays, deductibles, and non-covered services are **due at the time of service**. We accept cash, check, credit cards, and care credit. These charges cannot be waived by our practice, as they are a requirement placed on you by your insurance carrier. You are responsible for any non-covered services as determined by your insurance plan. Although we file claims for most insurance plans on your behalf, you are ultimately responsible for payment of the bill.

Past Due Balances: _____ INITIAL

You will be asked to pay any past due balances when making appointments or before seeing the dentist. If your balance is especially high, we can set up a three (3) month payment plan. Any account that has an unpaid balance after 60 days will be applied a 2% monthly service charge.

Returned Checks: _____ INITIAL

There will be a $35.00 charge added to your account for any check returned by your bank.

Missed Appointments: _____INITIAL

We request the courtesy of a 24hr notice when cancelling so that we can contact another patient who needs our care.

A **fee of $40** will be assessed per scheduled appointment for **Saturday appointments** and **4pm, 5pm and 6pm appointments.**

A **fee of $25** will be assessed per scheduled appointment for other times.

Collection Policy: _____ INITIAL

All efforts will be made to work with our patients on outstanding balances. If an account must be sent to collections and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.

SIGNATURE_____ DATE_____

Patient Name _____

Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now? If yes, please explain _____ _____	☐	☐
2. Have you ever been hospitalized for any surgical or serious illness within the last 5 years? If yes, please explain _____ _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? Please list: _____ _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you allergic to anything? If so, what: _____ _____	☐	☐
7. Have you ever had any problems with dental anesthetic?	☐	☐
8. Are you under treatment for **Osteoporosis?** Please list medications: _____	☐	☐
9. Have you ever taken bisphosphonate medications such as: Fosamax, Boniva, Actonel, Reclast?	☐	☐

10. CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR NOW HAVE:

High/Low blood pressure	Heart Attack
*Rheumatic Fever	Asthma
AIDS	Thyroid problems
Heart Disease	Pacemaker
*Heart murmur	Anemia
Emphysema	Cancer
Arthritis	Liver disease
Heart trouble	*Mitral Valve Prolapse
Diabetes	Hepatitis
Artificial Heart Valve	Oral Herpes/Cold Sores
Shortness of breath	TMJ
Venereal Disease	Stroke
Sleep Apnea	
*Hip, Knee or Joint replacement/implants	
Pain in chest, neck, arm or jaw on exertion	
Other _____	

11. **Do you need to Pre-Med with antibiotics for any of the above * conditions? _____**

Dental History

Date of Last Exam _____ Date of Last Full Series of X-Rays _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot/cold?	☐	☐
3. Do you feel pain in any of your teeth?	☐	☐
4. Do you have any sores or bumps in your mouth?	☐	☐
5. Do you have areas of concern today?	☐	☐
6. Are you interested in whitening your teeth?	☐	☐

7. CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOU:

Clicking of jaw joints	Loose teeth
Pain (jaw, ears or side of face)	Dizziness
Difficulty in opening or closing	Difficulty in swallowing
Frequent headaches	Snoring
Clenching or grinding of teeth	Excessive tiredness

Signature _____ Date _____

ANNUAL UPDATES: If nothing has changed, please initial & date line below

_____ _____ _____ _____ _____