

*Welcome*

*Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help you.*

**Ronald S. Benedetti, DDS**

**Michael G. Hoffman, DDS**

Located at: 600 Bankview Drive, Suite B, Frankfort, IL 60423

***Patient Information (confidential)***

*Date* \_\_\_\_\_

*Name* \_\_\_\_\_ *Prefer to be called* \_\_\_\_\_ *Gender* \_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Home Phone #* \_\_\_\_\_ *Cell#* \_\_\_\_\_ *Birth Date* \_\_\_\_\_

*Social Security #* \_\_\_\_\_ *Driver's Lic. #* \_\_\_\_\_

*Work Phone* \_\_\_\_\_ *Ext.* \_\_\_\_\_ *Email Address* \_\_\_\_\_

*In case of emergency, contact* \_\_\_\_\_ *relation* \_\_\_\_\_ *Phone* \_\_\_\_\_

*Who may we thank for referring you?* \_\_\_\_\_

***Responsible Party (to whom statements should be addressed)***

*Name* \_\_\_\_\_ *Relationship to patient* \_\_\_\_\_ *Gender* \_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Home Phone#* \_\_\_\_\_ *Cell#* \_\_\_\_\_ *Birth date* \_\_\_\_\_

*Social Security #* \_\_\_\_\_ *Driver's Lic. #* \_\_\_\_\_

*Employer* \_\_\_\_\_ *Position* \_\_\_\_\_ *Work Phone* \_\_\_\_\_

*Email Address:* \_\_\_\_\_

*Is this person currently a patient in our office?* \_\_\_ Yes \_\_\_ No

***Insurance Information***

*Name of Insured* \_\_\_\_\_ *Relationship to Patient* \_\_\_\_\_

*Birthdate* \_\_\_\_\_ *Social Security #* \_\_\_\_\_ *Employer* \_\_\_\_\_

*Ins. Co. Name (for above employer)* \_\_\_\_\_ *Group#* \_\_\_\_\_

*Ins. Co. Address:* \_\_\_\_\_ *Ins Co. Phone #* \_\_\_\_\_

*I agree to be financially responsible for this account according to the policies listed separately.*

*Signature* \_\_\_\_\_ *date* \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT THE PRESENT (CIRCLE SEPERATELY)

Heart Attack	YES	NO	Artificial Joints (hips, knees, etc.)	YES	NO	Hepatitis B	YES	NO
Angina Pectoris	YES	NO	Kidney Trouble	YES	NO	Hepatitis C	YES	NO
Heart Disease	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Heart Murmur	YES	NO	Diabetes	YES	NO	H.I.V. and/or AIDS	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Cold Sores	YES	NO
Arteriosclerosis	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Stroke	YES	NO	Latex Allergy	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Osteoporosis	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Pain in Jaw Joints	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
						Psychiatric Treatment	YES	NO

1. Has there been any change in your general health within the past year? ..... YES NO
2. Date of last physical \_\_\_\_\_.
3. Are you now under the care of a physician? ..... YES NO
4. Physician's name, address and telephone number \_\_\_\_\_
5. a. Are you taking any medication, pills or drugs (including daily aspirin)? ..... YES NO  
If yes, please list: \_\_\_\_\_
- b. Are you taking any vitamins, herbs, or dietary supplements? ..... YES NO  
If yes, please list: \_\_\_\_\_
6. Are you aware of being allergic to or have you ever reacted adversely to:
  - a. Local anesthetics? ..... YES NO
  - b. Penicillin or other antibiotics? ..... YES NO
  - c. Sulfa drugs? ..... YES NO
  - d. Barbiturates, sedatives or sleeping pills? ..... YES NO
  - e. Aspirin? ..... YES NO
  - f. Iodine? ..... YES NO
  - g. Codeine or other narcotics? ..... YES NO
  - h. Other \_\_\_\_\_
7. Do you have chest pain upon exertion? ..... YES NO
8. Are you ever short of breath after mild exercise or while lying down? ..... YES NO
9. Do your ankles swell? ..... YES NO
10. Have you had any serious trouble associated with any previous dental treatment? ..... YES NO  
If so, explain \_\_\_\_\_
11. Do you have any other disease, condition or problem not listed above? ..... YES NO  
If so, explain \_\_\_\_\_
12. Do you smoke or have you smoked in the past? ..... YES NO

WOMEN

13. Are you pregnant? ..... YES NO
14. Do you have any problems associated with your menstrual period? ..... YES NO
15. Are you taking birth control pills? ..... YES NO
16. Are you nursing? ..... YES NO

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Signature of Patient (or guardian)

Date

# Dr. Ronald Benedetti, Dr. Michael Hoffman and Associates

## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve 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 the 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH 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 and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications 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 was in effect. Unless you give us 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, or other person you may name, to the extent necessary to help with your healthcare or with payment for your healthcare.

**Persons Involved In Care:** We may use or disclose 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. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity 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 written authorization.

**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 disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may 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.



DENTAL PAYMENT POLICIES OF  
DR. RONALD S. BENEDETTI, D.D.S. & DR MICHAEL G. HOFFMAN, D.D.S.

**NEW PATIENTS:** Payment is expected in full at time of first appointment.

**WITH DENTAL INSURANCE**

Unless you intend to pay in full on each visit you must sign below. Some insurance companies require an original form for each visit.

Routine Cleaning and Periodic Exams: valid insurance form accepted in place of payment on day of service, (not including treatment of gum disease), if, we can verify your insurance at or before your visit. (Remember, we are unable to contact insurance companies on evenings and Saturdays.)

- Emergency Services: Payment in full is due at time of services.
- Fillings: 25% of the total fee plus remaining deductible is due at the time of service.
- Oral Surgery, Periodontics (gum disease) and Endodontics (root canals): 50% of total fee plus remaining deductible is due at the time of service.
- Crowns, Bridges, Removable Partial and Full Dentures: with pre-authorization, 50% of the total fee plus remaining deductible is due to begin work. Without pre-authorization, 50% to start with balance due upon completion.

If the patients' insurance does not remit payment within 60 days or is invalid at the time of service, the balance becomes due in full from the patient or responsible party for the account.

**I agree to be responsible for all charges not paid by my dental plan. I authorize release of information needed to submit claims to my insurance co. X**

**I authorize payment of dental benefits, otherwise payable to me, to the above named dentists.X**

**WITHOUT DENTAL INSURANCE**

- Routine Cleaning and Exam: Payment in full is due at the time of service.
- Emergency Services: Payment in full is due at the time of service.
- Fillings, Oral Surgery, and Periodontics (gum disease): Payment in full is due at the time of service.
- Endodontics (root canals): 50% is due to begin work with the balance due upon completion.
- Crowns, Bridges, Removable Partial and Full Dentures: 50% is due to begin work with the balance due upon completion.

**FOR ALL PATIENTS**

- Patients with overdue balances may not schedule further appointments until it is brought up to date.
- Any credit balances will be refunded to the patient within 30 days upon request.
- A \$25 service charge will be applied for all returned checks and the balance becomes due in full.
- A collector fee of up to one third of the total balance will be added to accounts turned over to an outside collection agency. I also agree to pay for all additional associated costs if my account is turned over to a collection agency or attorney and to release any information I have supplied this office in an effect to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collection agency fees and attorney fees.
- A 1.5 % per month finance charge will be applied to all balances carried over 30 days.
- Monthly payments are only offered through *Care Credit*, fees are due at the time of service.
- Payments may be made by cash, check, MasterCard, Visa or Care Credit.
- Patients with Delta Dental of IL, State of IL, employees of the State of IL, or Compdent Group #950 insurance will follow "Without Dental Insurance" policies, payment is due at time of service. We will file your claim for you.

**IT IS YOUR RESPONSIBILITY TO CAREFULLY READ AND UNDERSTAND THE PAYMENT POLICIES. IF YOU HAVE QUESTIONS, PLEASE FEEL FREE TO ASK US.**

**X**

Signature of patient or person responsible for payment

Date