# Cosimi Dental Implants & Periodontics

## Patient Registration

Date _____

Patient's Name _____
Last First Middle

If patient is under age 18, give parent's or guardian's name _____

Mailing Address _____Email:_____
Address City State Zip

Home Ph. _____ Cell Ph. _____Work Ph: _____

SSN: _____ Date of Birth: _____ Marital Status: S M D W Gender: M F

Best number to call you at? _____ May we leave a detailed message at this number? Yes No

Employer _____ Occupation_____

Spouse's Name _____
Last First Middle

Spouse's Employer _____Spouse's Occupation _____

Is an immediate family member a patient here? _____ Name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information (The responsible party MUST be present at all appointments and sign all documents.)

Self _____ Other _____
Yes/No Last First Middle

If "other" please complete:

Social Sec. # _____ Birth Date_____/_____/_____ Relationship to Patient _____

Address _____
Street City State Zip

Home Ph. _____ Cell Ph. _____ Work Ph. _____

## Dental Insurance Information

Insured's Name _____Insured's Social Sec. # _____ Birth Date_____/_____/_____

Insured's Employer _____

Insurance Company _____ Group No. _____ I.D. No. _____

Insurance Co. Address _____

Do you have any dual coverage? ☐Yes ☐No If yes, list primary _____

Insured's Name _____ Insured's Social Sec. # _____ Insured's Birth Date _____

Insured's Employer _____

Insurance Company _____

Insurance Co. Address _____
Street City State Zip

## Emergency Information

Name of nearest relative NOT living with you _____

Address _____
Street City State Zip

Phone No. _____

I understand that where appropriate, credit bureau reports may be obtained. I direct insurance benefits payable to the attending dentist.

**Signature** (Parent's signature, if minor) _____ Date _____

Reason for today's visit _____

1. Are you having pain or discomfort at this time?..... Yes No
2. Have you been a patient in the hospital during the past two years?..... Yes No
3. Have you been under the care of a medical doctor during the past two years?..... Yes No
   Physician's Name _____
   Address _____ Telephone _____
4. Have you taken any medication or drugs during the past two years?..... Yes No
5. Are you now taking any medication, drugs, or pills?..... Yes No

   If yes, please list: _____

   _____

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substances?..... Yes No

   If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Murmur…… | Yes | No | Venereal Disease……..… | Yes | No | Diabetes……. | Yes | No |
| Heart Pacemaker……..… | Yes | No | Hepatitis A (infectious)…… | Yes | No | Thyroid Problems……. | Yes | No |
| Mitral Valve Prolapse…… | Yes | No | Hepatitis B (serum)…….. | Yes | No | Tuberculosis……. | Yes | No |
| High Blood Pressure…….. | Yes | No | Hepatitis C…….…… | Yes | No | Asthma……. | Yes | No |
| Heart Surgery……. | Yes | No | A.I.D.S…….…. | Yes | No | Artificial Joints…… | Yes | No |
| Rheumatic Fever…… | Yes | No | H.I.V. Positive……..…….. | Yes | No | Psychiatric Treatment…. | Yes | No |
| Epilepsy or Seizures…….. | Yes | No | Bleeding Problems / Hemophilia….. | Yes | No | Cortisone Medicine…… | Yes | No |
| Fainting or Dizzy Spells…… | Yes | No | Radiation Therapy……..…… | Yes | No | Cancer…… | Yes | No |
| | | | | | | Other:_____ | | |

8. Do you Smoke? Yes No If yes: # of packs per day _____ ; # of cigarettes per day_____

9. Do you use Smokeless Tobacco? Yes No

10. Do you take aspirin daily? Yes No 11. Do you require a pre-med antibiotic for dental visits? Yes No Type:_____
    What dose? _____ Dose: _____

**For Women Only:**
Are you pregnant? ☐ Yes, due date _____ ☐ No
Are you nursing? ☐Yes ☐ No
Are you taking birth control pills? ☐ 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.

Patient Signature_____ Date_____

**Consent:**
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.
ANY PORTION OF A REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE SENT TO A COLLECTION AGENCY.

Patient_____Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

Cosimi Dental Implants & Periodontics

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Section A: PATIENT GIVING CONSENT**

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security # : _____

**Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Michael Cosimi

Telephone: 618/997-2403 Fax: 618/997-2487

Address: 408 Lincoln Dr.

Herrin,, IL 62948

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

Cosimi Dental Implants & Periodontics

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
NAME

office's Notice of Privacy Practices.

_____
Signature

_____
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

*Cosimi Dental Implants & Periodontics*

# FINANCIAL POLICY

## INSURANCE

1. Patient and/or responsible parties who have dental or health insurance should remember that professional services are provided and charged to the patient/responsible party, not the insurance company. Allowing time for the insurance company to process claims before collecting our fee is a courtesy we *may* extend to our patients- not an obligation.
2. We will submit insurance claims for the patient and/or responsible party unless other arrangements have been made.
3. We will ESTIMATE, to the best of our ability, the amount your insurance company will pay. We ask that you pay the difference between ESTIMATED coverage and the cost of the procedure at the time of service.
4. Should insurance pay more than the estimated amount, our office will gladly refund the difference.
5. Insurance companies pay benefits based on fees that they determine according to contracts negotiated with employers and/or individuals. They term these benefits "reasonable and customary rated" which may or may not be the prevailing fees in the area. The fees charged in our practice fall within most insurance company's "reasonable and customary rates". However, those who have a contract with a lesser quality insurance company, or those whose employers have purchased inferior plans may have "reasonable and customary rates" that fall below actual charges. Should this occur, the patient and/or responsible party is liable for the balance not covered by insurance. We will not be forced to let monetary considerations and insurance company policies interfere with providing the best possible care to our patients.
6. If a patient's insurance requires hospitalization to be predetermined, it is the patient's responsibility to notify our office.
7. The parent that accompanies a minor to the office will be responsible for the fees unless other arrangements have been made prior to the date of service.
8. (For DELTA Premier patients) Sixty days will be allowed for your insurance company to process the claim. If, after sixty days, no notice has been received from your insurance company, it is your responsibility to contact them directly. Regarding your insurance, you should remember that the entire balance is your responsibility at that time.

## LATE FEES AND/OR COLLECTION COSTS

1. A finance charge of 12% annually will be applied to any unpaid balance thirty (30) days after the date of service is rendered or thirty days after you insurance company has paid.
2. If, after sixty (60) days from the date of service your insurance company has failed to pay, your account will be subject to the finance charge.
3. If any balance is overdue and Legal or Collection assistance becomes necessary, the responsible party (guarantor) will be liable for charges incurred.

This signature is on file as my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Dr. Michael Cosimi/Cosimi Dental Implants & Periodontics, of the insurance benefits otherwise due me.

I have read the above financial policy and agree to the terms outlined therein.

Patient/Parent, Guarantor or Legal Guardian _____ Date _____

Cosimi Dental Implants and Periodontics

## *For Patients with Medicare*

As a non-participating provider, in compliance with Section 1802(3)(B) of the Social Security Act, we are required to have a private contract with all Medicare beneficiaries.

Please read the following statements and sign on the line provided.

- I understand that Dr. Michael Cosimi is excluded from the Medicare program.
- I, the beneficiary, or my responsible party accepts full responsibility for payment for Dr. Cosimi's charges for all services furnished.
- I understand that Medicare limits do not apply to what Dr. Cosimi may charge for services furnished.
- I agree not to submit a claim to Medicare or ask Dr. Cosimi or his staff to submit a claim to Medicare.
- I understand that Medicare payment will not be made for any items or services furnished by Dr. Cosimi that would otherwise be covered by Medicare if there were no private contract.
- I understand that I have the right to obtain Medicare covered services from providers who have not opted out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare covered services furnished by other providers who have not opted out.
- I understand that Dr. Cosimi's current opt out agreement runs from April 2, 2015-April 2, 2017, and that he intends to keep it current thereafter.
- I understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

I, the Medicare beneficiary or his/her responsible party, have read, understand, and agree to the terms outlined in this contract.

Signature of patient or responsible party: _____ Date: _____

# Cosimi Dental Implants and Periodontics
# Michael J. Cosimi, DMD, MS

## Consent to Share Confidential Health Information

***This form is optional***

Patient Name: _____ Date of Birth: _____

**I hereby authorize the staff of Cosimi Dental Implants and Periodontics to share:**

- ☐ Any and all health/financial information
- ☐ My appointment dates, times, and reasons
- ☐ Information about medications (pre-medications, prescriptions, etc.)
- ☐ Information about payments from me or my insurance, including cost of treatment
- ☐ X-rays and charts
- ☐ Other _____

**By phone, paper documentation, and/or email with the following people:**

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time by writing to Cosimi Dental Implants and Periodontics, but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or office to share my information with someone other than myself. I understand that this consent has no expiration date, unless cancelled by me in writing.

**Signature** of patient or legal guardian: _____ Date: _____

Name of legal guardian (if applicable): _____
Relationship to patient: _____

| For Office Use Only: Date entered: | Staff Initials: |
|---|---|