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4709 Golf Road, Suite 1005, Skokie, Illinois 60076
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http://abt-willis.com/index.html

WELCOME TO OUR OFFICE

Enclosed is a patient information form. Please complete both sides and bring it to your appointment, fax back to us or email us. We accept all forms of payment including, cash, check, credit cards FSA/HSA cards and CareCredit. If you have insurance, please bring your insurance card with you. We submit to all insurance companies but we may NOT be an in-network provider for your plan. We DO NOT participate in any HMO, DMO or discount plans.

We will submit the claim for you and bill you the balance on routine visits. Major procedures may require advance co-pay.

To process claims we need the name of your employer, a copy of your insurance card (front & back) or a completed claim form.

Also, enclosed is a records release form to be completed and brought to your appointment if you have recent x-rays from a former dentist.

We look forward to meeting you!

LIKE US ON FACEBOOK!
ABT & WILLIS FAMILY FOCUSED DENTISTRY!

PAUL J. WILLIS, D.D.S. ELLIOT ABT, D.D.S., M.S., M.Sc. RANDALL E. HIRSH, D.D.S.

PATIENT INFORMATION

(PLEASE PRINT) S.S.#_____ (IF YOU HAVE INS) DATE _____

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ OTHER CELL PHONE _____

PATIENT'S EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

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

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

PHYSICIAN'S NAME AND PHONE NUMBER_____

RESPONSIBLE PARTY (IF MINOR OR DEPENDENT)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE _____

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

DENTAL INSURANCE INFORMATION - PRIMARY

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ GROUP #_____ PPO _____ YES OR NO

INS. CO. ADDRESS_____ CITY _____ STATE _____ ZIP _____

INS. CO. PHONE NUMBER _____

NOTICE OF PRIVACY PRACTICES

BY SIGNING THE BACK OF THIS FORM, I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COPY OF THE DENTAL OFFICE'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THE NOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT MY DENTIST FOR MORE INFORMATION.

❑ **PATIENT REFUSES TO ACKNOWLEDGE RECEIPT:**

_____ _____

SIGNATURE OF STAFF MEMBER DATE

PLEASE COMPLETE
MEDICAL HISTORY ON BACK

FORM 030882 R/10/14 ITEM 8101

Medical History

Yes No Are you in good health?

Yes No Has there been any change in your general health within the past year? If yes, Explain _____

Yes No My last physical examination was on _____

Yes No Have you had any serious illness, operation, or been hospitalized in the past 5 years?

If so, what was the illness or problem? _____

Yes No Are you taking any medicine(s) including non-prescription medicine?

If so, what medicine(s) are you taking? _____

(CIRCLE ANY THAT APPLY, & EXPLAIN) Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, heart defects)
c. Do you have a cardiac pacemaker?
d. Asthma, hay fever or allergies
e. Diabetes
f. Hepatitis, jaundice or liver disease
g. AIDS or HIV infection or STD
h. Arthritis or painful swollen joints
i. Tuberculosis/Persistent cough
j. Low blood pressure - High blood pressure
k. Epilepsy or other neurological disease
l. Problems with mental health
m. Cancer
n. Problems of the immune system
o. Seasonal allergies

Have you had abnormal bleeding?

a. Have you ever required a blood transfusion?

Do you have any blood disorder such as anemia?

Have you ever had any treatment for a tumor or growth?

Are you allergic or have you had a reaction to:

a. Local anesthetics
b. Penicillin or other antibiotics
c. Other Medications _____
d. Latex

Have you had any serious trouble associated with any previous dental treatment?

If so, explain _____

_____

Do you have any disease, condition, or problem not listed above that you think we should know about?

If so, explain _____

_____

Has your physician instructed you to premedicate when visiting the dentist? If yes, please list the medication you take _____

_____

Women

Yes No Are you pregnant?

Yes No Are you nursing?

Yes No Are you taking birth control pills

By way of my signature, I provide the office of Drs. Willis, Abt, and Hirsh with my authorization and consent to use and disclose my protected dental care information for the purpose of treatment, payment and dental care operations.

By way of my signature, I agree to be responsible for all charges for dental services.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) EMAIL ADDRESS (OPTIONAL)

DR. PAUL J. WILLIS, D.D.S., DR. ELLIOT ABT, D.D.S., M.S., M.Sc., DR. RANDALL HIRSH, D.D.S.
4709 GOLF ROAD, SUITE 1005, SKOKIE, ILLINOIS 60076 847-677-2404
Email: abtandwillis@gmail.com Website: abt-willis.com

YOUR RIGHTS

Get an electronic or paper copy of your medical record	**•You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.**
	•We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	**•You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.**
	•We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	**•You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.**
	•We will say, "yes" to all reasonable requests.
Ask us to limit what we use or share	**•You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.**
	•If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	**•You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.**
	•We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	**•You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.**
Choose someone to act for you	**•If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.**
	•We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	**•You can complain if you feel we have violated your rights by contacting us using the information on page 1.**
	•You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
	•We will not retaliate against you for filing a complaint.

OUR USES AND DISCLOSURES

Treat you: We can use your health information and share it with other professionals who are treating you.

Run our practice: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services: We can use and share your health information to bill and get payment from health plans and other entities.

Comply with the law: We will share information about you if state and federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and for special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Change to the Terms of the Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

SEPTEMBER 23, 2013

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DENTAL INSURANCE AGREEMENT

As a service to our patients, we will bill your insurance company for your treatments. We collect the insurance portion of the dental fees directly from the insurance company. However, we must first verify your coverage before we can accept insurance assignment.

The insurance policy is a contract between the patient and the insurance carrier, NOT between the doctor and insurance company. The insurance company legally MUST answer to the patient. The insurance company is under no legal obligation to respond to us.

We can make no guarantee of any estimated coverage, but we will do our best to see that you receive your maximum benefits. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. If you would like to know what your expected coverage would be, we will submit a pretreatment estimate. Your insurer will generally send a detailed response within four to six weeks.

It is the patient's responsibility to be familiar with their insurance policy, covered and non-covered benefits, as well as with all kind of frequency limitations for regular check-up, cleaning, x-rays and waiting periods. Not every dental treatment is a covered benefit. Insurance companies arbitrarily select certain services they will cover. Most of the insurances cover only less expensive treatment. In any case the patient is responsible for the cost of dental treatment not covered by insurance contract.

We hope this information has been helpful. Please take the time to review your insurance policy's nuances thoroughly so that we may best serve you. As always, you may feel free to ask any member of out staff for clarification on services, billing and insurance.

SIGNATURE: _____ DATE_____

PAUL J. WILLIS, D.D.S.
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NEW PATIENT RECORDS REQUEST

I hereby authorize your office to send my records and/or x-rays to the above named office.

Patient Signature and Date_____

PATIENT(S) NAME_____

ADDRESS_____

PHONE NUMBER_____

DOB_____

RECENT FMX_____**RECENT BWX**_____

RECENT PROPHY_____

CONCERNS_____

Former Doctor's Name, Address, Phone Number and Fax_____

_____