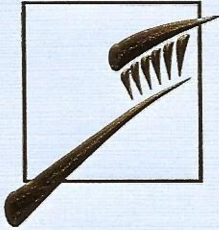

PATRICK J. YERKES, D.D.S.

Welcome!

Thank you for choosing our office for your dental needs. Please take a few moments to review and complete the following forms. You can bring the completed forms with you to your upcoming appointment and please call the office if you have any questions.

Business hours - M 8-5, T 10-7, W 9-12, Th 8-5, F 8-2
*Office hours may vary due to holidays/seasons
Phone number (815) 476-5248

If you have insurance we will verify your coverage and estimate your benefits prior to your visit. You may have a co-payment or deductible. Please be prepared to pay up to $50. If all goes as planned, we will have verified your coverage and be able to give you more details at your visit.

Those patients without insurance should be prepared to pay for your comprehensive examination and full-series of radiographs. Please call our office if you would like to discuss specific amounts.

All patients who have been treated elsewhere within the last three years should contact their previous dentist and ask that any recent *full mouth radiographs* be sent to our office directly. This may save time and money.

Your first visit will involve a comprehensive examination, necessary radiographs, and treatment planning. At the end of your visit, Dr. Yerkes will provide a comprehensive list of treatment, cost, and number of appointments necessary to complete the work. Once you feel comfortable with the treatment plan, appointments will be scheduled and treatment can begin.

We are located in the Berkot's complex on Rt. 53, near the Chinese restaurant. Just look for the neon tooth in the window.

Please let us know if you have any special needs or concerns. We are looking forward to meeting you.

688 W. Baltimore
Wilmington, IL 60481
(815) 476-5248

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: __________

E-mail Address: ______________________________

Name: ______________________________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: __________________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ___ SS#: ______________

Home Address: ______________________________ Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____)__________ Cell / Other #: __________

Wk #: (____)__________ Ext: ____ DL #: __________

Employer: ______________________________

Employer's Address: ______________________________

____
City State Zip

How long there? ______ Occupation: ______________

Where & when are best times to reach you? ______________

Whom may we Thank for referring you? ______________

Other family members seen by us: ______________

Previous / Present Dentist: ______________
(Please Circle)

Person Responsible for Account: ______________

2 SPOUSE INFORMATION

His / Her Name: ______________________________

Employer: ______________________________

Contact #: (____)__________ Ext: ____ SS #: __________

Birthdate: ___/___/___ DL #: ______________

Relative or Friend not living with you (for emergency).

His / Her Name: ______________ Relation: __________

Contact #: (____)______________________

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____
City State Zip

Insurance Co. Phone #: (____) ______________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: __________

Insured's Birthdate: ___/___/___ Insured's ID #: __________

Insured's Employer: ______________________________

Employer's Address: ______________________________

____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____
City State Zip

Insurance Co. Phone #: (____) ______________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: __________

Insured's Birthdate: ___/___/___ Insured's ID #: __________

Insured's Employer: ______________________________

Employer's Address: ______________________________

____
City State Zip

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

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature Date

Continued on Back

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________

Phone #: (_____)________________ Date of last visit: ________

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: ____________________

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: ________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Treatment
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: ____________

____

DENTAL HISTORY

Why have you come to the dentist today? ____________________

____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? ____________

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? ____________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

____

Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: ____________ Date: ____________

Doctor's Comments: ____________________

____

____

____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. ____________________

Patient Signature ____________ Date
Dentist Signature ____________ Date

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. ____________________

Patient Signature ____________ Date
Dentist Signature ____________ Date

 ©2015 INFORMS

Dr. Patrick Yerkes
General Office Policies

Thank you for choosing us as your dental provider. We are committed to helping you achieve the highest possible dental health. As it may take a little time to get to know each other, this will help explain how we handle scheduling, billing, co-payments, and other related business obligations associated with your treatment.

General: After an initial visit to perform a complete and thorough dental examination, Dr. Yerkes will provide a list of recommended treatment. (a treatment plan) You will and should ask as many questions as you like until you and Dr. Yerkes have fine tuned the plan to your needs and answered all questions. An estimated cost and number of appointments will be given to you in writing, at which time treatment can be scheduled.

Missed Appointments: In order to provide high quality care, proper time must be set aside for your treatment. Occasionally circumstances beyond your control may force you to cancel an appointment. If you must cancel an appointment we ask for 24-48 hour notice. This will enable us to offer that time to another patient and allow us to be more efficient, keeping costs down. A $25 lost time fee will be charged when multiple appointments are missed or cancelled within 24 hours of the appointment time.

Please initial____________

Billing and Payment: Payment for services is expected at the time of treatment. You will be expected to pay for treatment in full on the day of treatment. If you have insurance, you will be asked to pay only your co-payment and any deductible on the day of treatment. This will eliminate most billing and help to keep costs down. You will be given the amount to bring prior to your appointment. When dropping off older children, please make payment at the time of drop-off.

Please initial____________

Payment Options: We accept cash, Visa, MasterCard, and Discover. We can also set up a payment plan through CareCredit. This no interest payment plan option can spread your payments over 6 to 12 months once approved. Any payment plan must be set up prior to the beginning of treatment.

I will most likely pay by: Cash_____ Check_____ Credit Card_____ CareCredit Plan _____

Unpaid balances over 30 days old will be subject to monthly interest of 1% (APR 12%). If payment is delinquent, the patient will be responsible for reasonable collection, attorney, and court costs associated with recovery of monies due on the account. A grace period of 90 days will apply to balances a result of delayed insurance reimbursements. After 90 days, the patient will be asked to pay their balances in full. The patient will be reimbursed when and if the insurance makes payment.

We hope this will help reduce any confusion concerning our office policies. We understand dental treatment can be confusing, and you should feel free to ask any question, no matter how small, concerning your treatment or financial obligations.

I have read and understand the office policies of Dr. Yerkes. I agree to be responsible for all charges associated with the services rendered to me, or at my request, by Dr. Yerkes.

______________________________ Date:____________________
Signature of guarantor of payment / responsible party

______________________________ ____________________
Patient's Name Relationship to patient

Yerkes Family Dental

HIPAA Consent To Leave A Message

Patient Name: ______________________________ Date: ______________
(print)

I wish to be called at: (fill all that apply)

Home: ______________________________

Cell: ______________________________

Other: ______________________________

Regarding my care and follow-up.

- ❑ I do
- ❑ I do not

Give permission to leave relevant medical information on my answering machine or voice mail. These might include: treatment plans, pre-medication reminders, and general Protected Health Information.

- ❑ I do
- ❑ I do not

Want relevant medical information to be shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave Protected Health Information are:

1. ______________________________
2. ______________________________
3. ______________________________

______________________________ ______________

Patient Signature Date

Personal Health Information Disclosure Agreement

Yerkes Family Dental

I, ______________________________, do hereby grant permission for **Yerkes Family Dental** to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

____

____

____

____

____

Information to be disclosed (please check):

☐ Appointment dates and times

☐ Treatment plans and referrals

☐ Financial and billing information

☐ Any other pertinent dental health information related to treatment at this office.

☐ None of the above (please explain)

____

I understand that this permission will remain in effect unless a written cancellation has been provided to **Yerkes Family Dental**.

____

Patient Signature Date

____

Patient's Date of Birth

____

Witness Signature Date