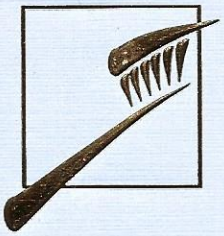

PATRICK J. YERKES, D.D.S.

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

CHILD REGISTRATION

Child's Name _____ Date _____

Birthdate _____ Age _____

Nickname _____ Hobbies _____

Parent's name _____

Residence-street _____

City _____ State _____ Zip _____

School _____

Telephone: Residence _____ School _____

Father employed by _____

Present Position _____ How long held _____

Mother employed by _____

Present Position _____ How long held _____

Referred by _____

Who will pay this account _____

Purpose of call _____

Name of father's dental insurance co. _____

Policy number _____

Name of mother's dental insurance co. _____

Policy number _____

Parents' Social Security numbers: Father _____

Mother _____

Parents' birthdates: Father _____

Mother _____

Item 539 09/03

Information For Emergency Treatment

Date of last medical examination _____

Does child have or has child ever had:	Yes	No
Anemia		
Diabetes		
Hepatitis		
Allergies		
To penicillin		
To local anesthetic		
Abnormal heart condition		
Abnormal bleeding from cut		
Rheumatic fever		
Heart murmur		
Is your child under the care of a physician now		
Is any medication being taken now		

If so, what _____

_____

Other physical conditions _____

_____

_____

Name of physician _____

Telephone number _____

Information given by (signature) _____

Date	Service Rendered	Charge	Credit	Balance

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 the personal health information of my minor child, _____, to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.) Please list name(s) and relationship…

_____

_____

_____

_____

_____

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**.

_____

Parent/Guardian Signature Date

_____

Patient's Date of Birth

_____

Witness Signature Date