Dr. Zak's Tooth Fairy Castle
2730 McFarland Rd.
Rockford, IL 61107
815-637-1700

Please return the completed forms at the new patient's visit.
DO NOT email or fax the completed forms back.
We need the original forms.

A parent must be here for the first visit.

Please bring your dental insurance card and driver's license with you to the appointment.

If you are a legal guardian,
YOU MUST HAVE *LEGAL GUARDIANSHIP DOCUMENTS FROM A JUDGE*
AND BRING THAT TO THE NEW PATIENT VISIT.
If you do not have legal guardianship paperwork from a judge we will not be able to see the child until you can provide legal paperwork.

If you need to cancel or reschedule, please be sure to call the office.
If it is before or after hours, stay on the line and the answering service will pick up.

The deposit of $25 is NON-REFUNDABLE if you do a no show no call.

Thank you.

Joseph Zakarija, D.D.S., M.S. Pediatric Dentistry and Braces for Children
2730 McFarland Road Rockford, IL 61107 Phone: (815)637-1700 Fax: (815)637-1513

Date _____ Preferred nickname _____

Patients Name _____ _____ _____
First Middle Last

Birthday _____ Male ____ Female ____ Phone number # _____

Address _____

City _____ State _____ Zip Code _____

PLEASE NOTE THAT THE ONLY PEOPLE LISTED ON THIS FORM WILL BE THE ONLY PEOPLE THAT WE ARE ABLE TO GO OVER ACCOUNT INFORMATION WITH

Parent/ Legal Guardian _____ DOB _____
(Print name)
Social Security# _____

Relationship to Child: Father _____ Stepfather_____ Mother_____ Stepmother_____ Legal Guardian _____

Legal Foster Mother _____ Legal Foster Father _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Address (If different than patient) _____

City _____ State _____ Zip Code_____

Home phone# _____ Cell Phone #_____

Place of Employment _____ Work Telephone #_____

Work Address_____

City _____ State_____ Zip Code_____

Parent/Legal Guardian _____ DOB_____
(Print name)
Social Security #_____

Relationship to Child: Father _____ Stepfather_____ Mother_____ Stepmother_____ Legal Guardian _____

Legal Foster Mother _____ Legal Foster Father _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____

Address (If different than patient) _____

City _____ State _____ Zip Code_____

Home phone# _____ Cell Phone #_____

Place of Employment _____ Work Telephone #_____

Work Address_____

City _____ State _____ Zip Code_____

Are there any other family members who are patients here? If yes, please list:

_____ Relationship_____

CONTINUED ON REVERSE ➡

Dental History

Is this the patient's first visit to a dentist? _____ ..... If yes, please give the approximate date of the last visit_____
Has the patient ever had dental x-rays taken? _____ ..... If yes, was it within the last 12 months? _____
Has the patient ever had a prophylaxis (teeth cleaning)? _____ ..... If yes, was it within the last 6 months? _____
Has the patient ever had fluoride treatment? _____ ..... If yes, was it within the last 12 months? _____

Is the patient having any toothaches or dental complaints? _____ ..... If yes, describe_____

Has the patient ever had any unfavorable dental experiences? _____ ..... f yes, describe _____

Medical History

Has the patient had any history or difficulty with any of the following? (If yes, please check)

- ❑ Kidney Disease
- ❑ Chicken Pox
- ❑ Mumps/Measles
- ❑ Down Syndrome
- ❑ Diabetes
- ❑ Hepatitis
- ❑ AIDS/HIV
- ❑ Rheumatic/Scarlet Fever
- ❑ Seizure Disorder/Epilepsy
- ❑ Developmental Delays
- ❑ Bleeding Problems/Hemophilia
- ❑ ADD/ADHD
- ❑ Cerebral Palsy
- ❑ Autism Spectrum
- ❑ Hearing/Speech Impairment
- ❑ Sensory Disorder
- ❑ Mobility Limitations
- ❑ Apprehension

If yes to any of the above, please describe or list any health concerns not listed: _____

_____

Has the patient had any history of cardiac disease including heart surgery, murmur, etc.? _____YES _____ NO

If yes, please describe_____

_____

Please note: Physicians will require some patients with a history of heart disease to have antibiotic therapy for safe dental work.
Does your child require antibiotics for dental work? _____YES _____ NO _____ UNSURE ***If unsure please consult your physician.***

Please list any allergies: _____

_____

Is the patient taking any medications? If yes, please list. _____

_____

Physicians Name_____ Phone Number _____

Insurance Authorization

Is the patient covered by dental insurance? _____ If yes please fill out the accompanying insurance record or attach a completed and signed claim form. We must have the policy holders' signature below and a completed claim form or insurance record in order to file your claim. IF WE DO NOT HAVE YOUR INSURANCE INFORMATION THE PERSON RESPONSIBLE FOR THE ACCOUNT MUST PAY FOR THE VISIT WHEN SERVICES ARE RENDERED.

I authorize the release of information to all my insurance carriers. I authorize payment directly to my doctor. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ Date _____
Signature of Policy Holder

Medical Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____ Date _____
Signature of Parent/ Legal Guardian

CONTINUED ON FRONT

Financial Policy for the office of Dr. Joseph Zakarija D.D.S., M.S.

If you have any questions, please do not hesitate to ask. A copy of our policy will be provided upon request.

No Insurance/Self Pay:
Payment is required in full at the time of service. For your convenience we accept cash, checks, check cards, MasterCard, Visa and Discover. We do not accept the medical card, Kid care.

Insured Patients:
Insurance is a contract between you and your insurance company. We will file your insurance claim as a courtesy. You are responsible for the remaining unpaid balance. If your insurance does not pay within 60 days of your submitted claim, then we will request payment in full of the responsible parent/guardian. If your insurance pays after a payment has been received from you and there is a positive balance we will reimburse the policy holder directly. If there is a dispute or discrepancy with your insurance plan it will be your responsibility. We suggest that you contact your employers Human Resource department for additional assistance.

Our fees are set and do not fluctuate based on our insurance company or self pay patients. We are not in any network and charge the same fees for all services to all patients. We do not keep pre-estimate requests. It is your responsibility to know your plan coverage, deductibles, maximums, and remaining benefits for each calendar year.

We do not file claims with medical insurance or any workman's compensation claims. If you are receiving funds from a foundation or fund, we will provide you with a letter upon request. However, collecting from these organizations will be the sole responsibility of the parents/guardians.

We will do our best to assist you in any way. However, it will be your responsibility to follow-up if there is a dispute or discrepancy with your dental insurance coverage.

Rebilling Fees & Delinquent Balances:
Any balance not paid by the due date may be subject to rebilling fees. In the event that we must re-bill you for constant late fees; we reserve the right to change your account status to cash only-self pay regardless of your insurance coverage.

Failed Appointments:
Knowing the date and time of your child's appointment is your responsibility. *Courtesy calls are made when possible, however, it is your responsibility to call and cancel within 24 hours of your child's appointment or a failed appointment fee will be charged per child.* A history of cancellation and missed appointments may result in being denied services and being released as a patient.

Orthodontics:
Orthodontic patients will have specific payment arrangements. You will receive a separate packet with detailed payment arrangements regarding orthodontic services, policies, and payment requirements.

OVER →

Parent/Guardians:

I understand that the office will not become involved in parental financial arrangements or disputes. We will not set up separate accounts for billing purposes. Billing arrangements between parents and guardians are your responsibility. A parent/guardian's signature is required stating they understand all of the financial policies listed.

If your account defaults and is sent to collections your entire family is released from our care.
This includes all family members and all accounts.

Should I default in payment, I agree to pay all costs of collection, including collection agency fees, which could be as much as 50%, court costs and reasonable attorney fees.

Child's Name: _____ (please print)

Parent/Legal Guardian's Name: _____ (please print)

_____ _____
Parent/Legal Guardian's Signature Date

HIPAA

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

We respect your legal obligation to keep health information that identifies your privacy. We are obligated by law to give you notice of our policy practices. This notice describes how we protect your health and what rights you have regarding it.

Treatment, Payment, and Health Care Operations

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are; setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care services; or getting copies of your health information from health care professionals that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking health care or dental care plans, or other sources of payment; preparing and sending bills or claims; and collection of unpaid amounts (either ourselves or through a collection agency or attorney.) "Health Care Operations" mean those administrative and managerial functions that we must do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance; personnel decisions; participation in managed care plans, defense in legal matters, business planning, and outside storage of our records.

Our Notice of Privacy Practices

By law we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office for you.

***Copies of the Notice of Privacy are given out at the front desk, please retain a copy for your records. ***

_____ _____
Parent/Legal Guardian's Signature Date

PRIMARY INSURANCE RECORD

Patients Name: _____ DOB: _____

Policy Holder (person with insurance) _____

Social Security # _____ Birthdate: _____

Home address: _____ City: _____

State: _____ Zip: _____

Relationship to patient: ○ Father ○ Mother ○ Legal Guardian ○ Foster parent

Employer/Local: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone number: _____

Insurance Company: _____

Insurance address to mail claims: _____

City: _____ State: _____ Zip: _____

Customer Service Phone #: _____

Group Number: _____ Member ID: _____

Subscriber ID: _____ Payor ID: _____

Note: Your place my not use the above numbers. The member ID will be issued by your insurance and will be used instead of your SS#.

If you also have secondary insurance, please fill out the backside.

Per insurance, if you have primary and secondary insurance the primary holder will be the person whose birthday falls first in the year.

SECONDARY INSURANCE RECORD

Patients Name: _____ DOB: _____

Policy Holder (person with insurance) _____

Social Security # _____ Birthdate: _____

Home address: _____ City: _____

State: _____ Zip: _____

Relationship to patient: ○ Father ○ Mother ○ Legal Guardian ○ Foster parent

Employer/Local: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone number: _____

Insurance Company: _____

Insurance address to mail claims: _____

City: _____ State: _____ Zip: _____

Customer Service Phone #: _____

Group Number: _____ Member ID: _____

Subscriber ID: _____ Payor ID: _____

Note: Your place my not use the above numbers. The member ID will be issued by your insurance and will be used instead of your SS#.

Per insurance, if you have primary and secondary insurance the primary holder will be the person whose birthday falls first in the year.