PATIENT INFORMATION

First Name: ______________________ MI: _____ Last: ______________________________ Nick Name: ________________

Home Phone: ____________________ Work Phone: ___________________________ Cell Phone: ____________________

DOB: ____________________________ Male _____ Female _______ SS#: ____

Address: _____________________________________ City: ______________________ State: ______ Zip: ____________

Employer: ____

State ID/Drivers License #: ______________________________ E-mail Address: __________________________________

Name of Physician: _________________________________ Physician Phone: ____________________________________

In Case of Emergency Contact: _________________________ Relationship: _________________ Phone: ________________

How did you hear about this office? ____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	❑	❑	Epilepsy	❑	❑	HPV	❑	❑	Psychiatric Care	❑	❑
Alcoholism	❑	❑	Glaucoma	❑	❑	Jaundice	❑	❑	Radiation Treatment	❑	❑
Allergies	❑	❑	Hay Fever	❑	❑	Kidney Disease	❑	❑	Respiratory Problems/Disorders	❑	❑
Anemia	❑	❑	Head Injuries	❑	❑	Kidney Dialysis	❑	❑	Rheumatic Fever	❑	❑
Arthritis	❑	❑	Hearing Impaired	❑	❑	Latex Sensitivity	❑	❑	Rheumatism	❑	❑
Asthma	❑	❑	Heart Disease	❑	❑	Lupus	❑	❑	Scarlet Fever	❑	❑
Blood Disease	❑	❑	Heart Valve, Murmur	❑	❑	Low Blood Pressure	❑	❑	Seizures/Fainting spells	❑	❑
Bone Disease	❑	❑	Pre-Med ____________			Malignancies	❑	❑	Sinus Problems	❑	❑
Cancer	❑	❑	Date ____________			Mitral Valve Prolapse	❑	❑	Stomach Ulcers	❑	❑
Chemical Dependency	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Stroke	❑	❑
Chest Pain	❑	❑	Type(s) ____________			Nervous Problems/Disorders	❑	❑	Thyroid Disease	❑	❑
Circulatory Problems	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tuberculosis	❑	❑
Convulsions/Seizures	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Tumors or Growths	❑	❑
Diabetes	❑	❑	Hip or Joint Replacement	❑	❑	Pre-Med ____________			Ulcers	❑	❑
Excessive Bleeding	❑	❑	Pre-Med ____________			Date ____________			Venereal Disease	❑	❑
			Date ____________								

Medical Questions

List any medications you are taking including non prescription drugs:

____

____

____

____

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list below:

____

Are you in good health? ❑ Yes ❑ No

Date of last medical exam: ______________________

Have you ever been hospitalized? ❑ Yes ❑ No If yes, what was the problem

____

____

Do you have any disease/problem you think we should know about? ❑ Yes ❑ No

____

____

____

____

Have you had a transplant operation that has depressed your immune system?

❑ Yes ❑ No If yes, please provide date ______________

Have you had an allergic reaction to Bananas? ❑ Yes ❑ No

Do you smoke or chew tobacco? ❑ Yes ❑ No

Have you had Heart Surgery? ❑ Yes ❑ No

Are you now under the care of an MD? ❑ Yes ❑ No

Are you taking or have you ever taken bishosphonates?
(Forsamax or Actonel for osteoporosis, chemotherapy, etc.) ❑ Yes ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ Yes ❑ No

Are you nursing/breast feeding? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Expected delivery date: ____________________

Is there a possibility of pregnancy? ❑ Yes ❑ No

NOTE: Antibiotics (such as penicillin) may alter the affect of birth control pills. Consult your physician/gynecologist for assistance regarding addition methods of birth control.

Dental History Information

Date of dental visit? ____________________

Name of your previous dentist ____________________

Reason for today's visit? ____________________

Have you ever had an oral cancer screening ❑ Yes ❑ No

How often do you floss your teeth? ____________________

Do your gums bleed when you brush? ❑ Yes ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ Yes ❑ No

Have you ever had complications from an extraction? ❑ Yes ❑ No

Have you ever had a popping or clicking near your ear when you chew? ❑ Yes ❑ No

Are you prone to frequent headaches? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Do you have sores, blisters or swelling on your gums, lips or cheeks? ❑ Yes ❑ No

Have you ever had orthodontic treatment? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Do you have problems with bad breath? ❑ Yes ❑ No

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? ❑ Yes ❑ No

Have you ever used an electric tooth brush? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ Yes ❑ No

On a scale from 1 to 10 with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be?

- ❑ Whiter
- ❑ Straighter
- ❑ Close Space
- ❑ Replace black mercury filling with tooth colored restorations
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Less gum showing
- ❑ Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: ____________________ Date: ____________

Parent/Guardian *(if patient is a minor)* ____________________ Date: ____________

Reviewed by: ____________________ Date: __________ Dr.. Signature: ____________________ Date: __________

HIPAA

PATIENT CONSENT / ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Chicagoland Smile Group, our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting our office and requesting a revised Notice. We will post any revised Notice in the office.

You have the right to request our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care options, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONSENT OF THE NOTICE OF PRIVACY.

NAME _______________________________________ DATE____________________

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT / ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

COMMUNICATION POLICY AND WAIVER

Á

Patient Name: ____

Whom may we thank for referring you to our practice?

- ☐ Another Patient Name: ____
- ☐ Dental Office
- ☐ Insurance Carrier
- ☐ Website
- ☐ Google
- ☐ Other ____________________________________

Communication is a very important part of providing quality healthcare. In an effort to provide you with timely information regarding your health care, please complete this form.

We normally contact our patients between 9:00am and 7:00pm. Please provide the phone numbers and/or email that we may use to contact you during that time period:

Home: _____________________ Work: _______________________ Cell: _______________________

If we need to reach you outside these hours, what is the best phone number that we should use to contact you?

Home or **Work** or **Cell**

May we contact you by email? **Yes** or **No**

If yes, what is your email address? ____

If you are unavailable at the time we contact you, may we leave medical information with another person?

Yes or **No**

If yes, name of person: ____________________________________ Ph#: ___________________________

May we leave any information on voicemail or answering machine? **Yes** or **No**

____ ____________________________

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

How We May Use or Disclose Your Health Information

Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other healthcare professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and healthcare professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so..

Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Lawsuits and Legal Actions Law Enforcement Purposes.. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice.

FINANCIAL POLICY

We at Chicagoland Smile Group are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition we are also dedicated to making top quality care as cost effective as possible. To promote a long term mutually satisfying relationship, we would like to explain our office policy regarding payment options, insurances, appointments and fees.

PAYMENT OPTIONS: Payment for service is due at the time that services are rendered. When insurance applies we will collect any deductible and/or estimated co-payment at the time of service. We accept cash, check, Visa, Mastercard and Discover. In addition we offer financing through Citicard, Care Credit and Springstone for those requiring payment plans. Payments made with a credit card, debit card, or financing by a third party are not eligible for challenges after services have been provided. This means once we debit your card, the charge cannot be reversed for any reason. By signing below you agree to not challenge the credit, debit or financing card payments once services are provided.

INSURANCE: We will gladly discuss your proposed treatment, answer any questions relating to you insurance and provide you with an ESTIMATE of what your insurance company will pay towards your treatment. Our office can make no guarantee of the actual payment by your insurance company. Filing of insurance claims is a courtesy we extend to our patients. You must realize; however, that your insurance is a contract between you, your employer and your insurance company. You are FULLY RESPONSIBLE for the charges for the treatment rendered.

MISSED APPOINTMENTS: Appointments are made on a per appointment basis and this time is reserved exclusively for you. A s a courtesy, we attempt to remind you of your appointment by calling you, sending emails and/or texts to those patients who have signed up for these options; however, it is ultimately the patient's responsibility to keep their scheduled appointments.

When you fail to notify us of your inability to keep your appointment, another patient in need of dentistry is unable to receive treatment. We require that you give us at least 48 hours notice when you realize that you cannot keep your scheduled appointment. A fee of $50 will be charged for all missed and short notice (less than 48 hour notice) cancelled appointments. We strongly encourage you to keep any appointments that you schedule as there may be a wait to reschedule, especially when it comes to evening and Saturday appointments. After hours, our office has a 24 hour answering service that allows you to speak directly to someone.

Your signature below acknowledges that you received this form and you fully understand all of our policies.

SIGNATURE ______________________ DATE ______________