ILLINOIS FAMILY DENTISTRY

Today's Date: _____

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

First Name: _____ **Last Name**: _____ **Middle Initial**: _____

Address: _____ **City:**_____

State: _____ **Zip**: _____ **Email**: _____

Home Phone #: (_____) _____ **Cell Phone:** (_____) _____

Date of Birth: _____ **Age:** _____ **Sex: Female** [ ] **Male** [ ]

Emergency Contact Name: _____ **Emergency Phone #:** (_____) _____

How did you hear about us? A friend/patient _____ A Doctor _____ Staff _____ Insurance _____
Drive by ____ Website _____ Google _____ Facebook ____ Direct Mailer ____ Flyer ____ Business Card_____

RESPONSIBLE PARTY INFORMATION: (List person responsible for bill - use full legal name)

First Name: _____ **Last Name:** _____ **Date of Birth:** _____ **Social Security:** _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____ **Email:** _____

Cell Phone: (____) _____ **Employer Name:** _____ **Occupation:** _____ **Work Phone:** (_____) _____

Work Address: _____ **City:** _____ **State:** ___ **Zip:** _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance and ID cards)

PRIMARY INSURANCE

Policy Holder's Name: _____ **Insurance Name:** _____

Policy Holder's Social Security #: _____ **Policy Holder's DOB:** _____

Member ID #: _____ **Group #:** _____ **Effective Date:** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist/dental group. I understand that I am financially responsible for any balance. I also authorize Illinois Family Dentistry or insurance company to release any information required to process my claims.

_____ _____

Patient / Guardian Signature **Date**

ILLINOIS FAMILY DENTISTRY

Date: _____

Medical Health History

Patient Name: _____ **Date of Birth:** _____

Name of Personal Physician: _____ **Physician's Phone #:** _____

Date of last medical visit: _____ **Current Health: Excellent** _____ **Good** _____ **Fair** _____ **Poor** _____

Do you smoke or use chewing tobacco? Yes _____ **No** _____ **If Yes, how much per day?** ____

Date of last dental visit: _____ **Reason for visit:** _____

Primary concern for visit today? _____

AIDS/HIV+	YES	NO
Allergies	YES	NO
If yes, what? _____		
Anemia	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Blood Disease	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Dizziness	YES	NO
Epilepsy	YES	NO
Fainting	YES	NO
Excessive Bleeding	YES	NO
Hay Fever	YES	NO
Heart Disease	YES	NO
High Blood Pressure	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Pacemaker	YES	NO

Currently Pregnant	YES	NO
If yes, week #? _____		
Head Injuries	YES	NO
Respiratory Issues	YES	NO
Sinus Problems	YES	NO
Stroke	YES	NO
Tumors	YES	NO
Latex Allergy	YES	NO
Venereal Disease	YES	NO
Codeine Allergy	YES	NO
Penicillin Allergy	YES	NO
Sulfa Allergy	YES	NO
Other Allergies	YES	NO
If yes, what? _____		
Radiation Treatment	YES	NO
Rheumatism	YES	NO
Stomach Problems	YES	NO
Tuberculosis	YES	NO
Autism	YES	NO

Are you taking any medications? If so, what?

_____

_____

_____

_____

Are you taking birth control? YES NO
If antibiotics are prescribed, it is recommended to use alternative birth control methods to prevent unplanned pregnancy

Do you have any disease or medical problems NOT listed on this form? If so, what is it?

_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____

Patient / Guardian's Signature **Date**

INFORM CONSENT FOR XRAYS, EXAM, CLEANING AND TREATMENT

I authorize Illinois Family Dentistry and staff to take radiographs, study models, intraoral photographs, or any other diagnostic tools, all deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment including cleaning, fluoride and sealants. And further authorize and consent that the dentist choose and employ assistance as deemed fit.

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

INFORMED CONSENT FOR RADIOGRAPHS (X-RAYS): This office follows the guidelines of the American Dental Association and recommends that FULL MOUTH XRAYS (FMX) BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITE WING XRAYS twice a year for caries active patients and once annually for routine cases. Current Xrays will be necessary before any diagnosis can be finalized. NO TEETH WILL BE EXTRACTED without a current PA (periapical xray showing the root and surrounding bone and soft tissue). No fillings will be placed without current bitewings and/or PAs of the tooth. NO EXCEPTIONS.

CHILDREN AND ADULTS: If any decay or dental infection (abscess) is obvious on visual inspection, xrays will be necessary to assess the extent of damage to the tooth structure. If your child is uncooperative. you will be referred to a pediatric dentist for treatment. Bite-wings and occlusal films are recommended for school age children 5 yrs and up. Bite-wing xrays may be suggested at age 3 to 4 yrs if there is no spacing between the teeth and if we suspect caries.

PREGNANT WOMEN: XRAYS WILL BE TAKEN UNLESS CONTRAINDICATED BY MEDICAL RELEASE. Please inform this office if you think you are pregnant and xrays will be postponed until clearance received.

ROUTINE CLEANING: Treatment involves removing the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus, which is an accumulation of hard deposits on the tooth above the gingival margin. I understand that my gums may bleed or swell and I may experience moderate discomfort for several hours. There may be slight soreness for a few days. I will notify the office if conditions persist beyond a few days. I understand that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that I may receive a local anesthetic and/or other medication.

I agree to cooperate fully with the recommendations of the Dentist and I realize that failure to do so may result in less than optimum results and compromise the life span of my/my child's treatment. I also agree to follow the recommendations for home care and the schedule for future tooth cleaning and check-ups. I realize that failure to do my part in the maintenance of my/my child's oral health will compromise the success of any dental treatment received.
I understand that antibiotics, local anesthesia, and all other medications given to the patient before, during and after treatment, can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Administration of local anesthesia may cause nerve damage (paresthesia) that can last for days, months or indefinitely. Women of childbearing age need to know antibiotics may make birth control medications ineffective and need to rely on other methods of birth control to prevent pregnancy.
I understand and acknowledge that I may choose not to be treated by the dentist. The dentist has explained to me the reasonably foreseeable risks associated with not treating my condition. Alternative treatment plans with their foreseeable associated risks and benefits have been adequately presented to me.

Patient or Guardian Signature _____ Date_____

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.

Financial Responsibility Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: (_____) _____

If patient is under the age of 18, name of the individual who is financially responsible for Patient,

_____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update Illinois Family Dentistry at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Illinois Family Dentistry. We do accept payments from the dental insurance companies; however, we are not contacted with them. It is contract between you, your employer and the insurance company.

If requested, we will provide you with a verbal **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly **ESTIMATES** and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arise with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of services becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided.

I authorize the use of this signature on all my insurance submissions, whether manual or electric.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

Patient/Guardian Signature: _____ **Date:** _____

Notice of Privacy Practice

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures you have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____

Relationship to Patient: Self or Guardian (please circle one)