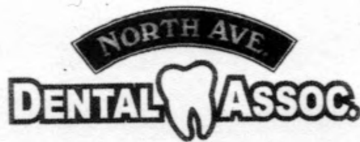


1933 Franciscan Way ● West Chicago, Illinois 60185
Phone 630.231.4500 ● Fax 630.231.4505

About You

Patient Name: ______________________ Last: ______________________

DOB: ______________ Age: ______________ SSN# ______________ Male: _____ Female: _____

E-mail: ____

Home Address: ____

City, State, Zip code ____

Single: _____ Married: _____ Divorced/Separated: _____ Widowed: _____ Child: _____ Other: _____

Home#: (____)____________ Cell#: (_____)____________ Work#:(____)____________ other#:(_____)____________

In an emergency who should be notified? Please enter Name and Phone number below:

____

Whom may we thank for referring you to our practice? ______________________

Other family members seen by our office? ______________________

Primary Insurance

Primary Insurance Co.: ______________________ Insurance Co. Address: ______________________

Insurance Phone #: (____) ______________________ Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________ Last: ______________ Relation: ______________ Insured's Birthdate: ______________

Insured's ID/SSN# : ______________________ Insured's Employer: ______________________

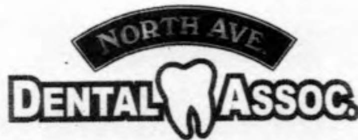
Secondary Insurance

Secondary Insurance Co.: ______________________ Insurance Co. Address: ______________________

Insurance Phone #: (____) ______________________ Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________ Last: ______________ Relation: ______________ Insured's Birthdate: ______________

Insured's ID/SSN# : ______________________ Insured's Employer: ______________________



1933 FRANCISCAN WAY ● WEST CHICAGO, ILLINOIS 60185
PHONE 630.231.4500 ● FAX 630.231.4505

HEALTH HISTORY FORM

DENTAL HISTORY

Why are you here today? ______________________________

____

Currently in pain? □ Yes □ No
Are your teeth sensitivity to cold or hot foods? □ Yes □ No
Are your teeth sensitive to biting? □ Yes □ No
Do you have any loose teeth? □ Yes □ No
Do you require antibiotics before treatment? □ Yes □ No
Any serious problems with previous dental work? □ Yes □ No
Brush Daily? □ Yes □ No Floss Daily? □ Yes □ No
Do your gums bleed when you brush or floss? □ Yes □ No
Have you been diagnosed with periodontal disease? □ Yes □ No
Do you have dry mouth? □ Yes □ No
Do you have TMJ (jaw joint) pain or clicking? □ Yes □ No
Are you happy with your smile? □ Yes □ No
If not, what would you change? ______________________________

____

____

Are you interested in orthodontic treatment? □ Yes □ No
Are you interested in cosmetic dental treatment? □ Yes □ No
Are you interested in tooth whitening? □ Yes □ No

MEDICAL HISTORY

Do you currently have a primary care physician? □ Yes □ No
Physician's Name: ______________________________
Phone #: ________________ Date of Last Visit: ________________
Are you currently under the care of a physician? □ Yes □ No
Please explain: ______________________________
Do you take prescription medications? □ Yes □ No
Please list: ______________________________

____

____

____

Do you have any allergies? □ Yes □ No
Please list: ______________________________

____

Have you recently been hospitalized? □ Yes □ No
When and for what? ______________________________
Do you smoke: □ Yes □ No How many packs per day? __________
Please list any additional medical conditions or hospitalizations that you have had: ______________________________

____

Have you ever taken a bisphosphonate drug (Fosamax)? □ Yes □ No
Have you ever taken Phen-fen? □ Yes □ No

Have you ever had any of the following medical problems?

□ Y □ N ADHD
□ Y □ N Anemia
□ Y □ N Autism
□ Y □ N Asthma
□ Y □ N Autoimmune disease
□ Y □ N Arthritis
□ Y □ N Artificial heart valve or joints (knee, hip, etc.)
□ Y □ N Bleeding abnormalities
□ Y □ N Cancer / Chemotherapy / Radiation
□ Y □ N Congenital heart defect
□ Y □ N Diabetes (Type I or II)
□ Y □ N Difficulty laying back or sitting up
□ Y □ N Dimensia
□ Y □ N Dizziness
□ Y □ N Down Syndrome
□ Y □ N Emphysema / Chronic bronchitis
□ Y □ N Excessive Bleeding
□ Y □ N Epilepsy
□ Y □ N Glaucoma
□ Y □ N Head Injuries
□ Y □ N Heart attack or stroke
□ Y □ N Heart murmur or arrhythmia
□ Y □ N Heart surgery / pacemaker / defibrillator
□ Y □ N High Blood pressure
□ Y □ N HIV / Hepatitis
□ Y □ N Infective endocarditis / joint infection
□ Y □ N Jaundice
□ Y □ N Kidney disease
□ Y □ N Liver disease
□ Y □ N Mental Disorders
□ Y □ N MVP
□ Y □ N Nervous Problem
□ Y □ N Respiratory Problems
□ Y □ N Rheumatic Fevers
□ Y □ N Rheumatism
□ Y □ N Sinus Problems
□ Y □ N Sickle Cell Disease / Trait
□ Y □ N Stomach Problems
□ Y □ N Thyroid problems
□ Y □ N Tuberculosis

Print Name ______________________________

Patient Signature ______________________________

Date __________

Office Policy Disclosure & Consents

Missed Appointment Fee

I agree to pay a fee of $75 to North Ave Dental Assoc. for failing to keep an appointment without notification 2 office days before the scheduled appointment.

Privacy Policy

I authorize appointment information to be left on my telephone answering machine or cell phone voice mail.

I authorize North Ave Dental Assoc. and its agents to communicate with any third parties (i.e. insurance carriers or other doctors) as deemed necessary regarding my health and financial information. And I authorize any third party to communicate my health and financial information to North Ave Dental Assoc.

I allow North Ave Dental Assoc. to use any photographs taken for educational and promotional purposes, without compensation.

Changes to Treatment Plans

Treatment plans are estimates only. Dental conditions may be worse than they appear in exams and in x-rays. Fillings may be deep enough to require root canal treatment. Sealants may become fillings. Fillings may be large enough to require crowns. Filling may become sensitive after a few weeks or months and require root canals and/or crowns. Conditions may require treatment from specialists.

I agree to be financially responsible for all fees that result from a change in my treatment plan.

Insurance Policy

At North Ave Dental Associates we accept dental insurance as partial credit for the services you receive. You will be responsible for paying your portion at the time your services are rendered.

The portion that we collect at the time of service is based on percentages of coverage and deductible information given by the insurance company. If the insurance company's payment is less than we estimated, then you will be responsible for the balance.

The only way to be certain what insurance will cover is to submit a Pretreatment Estimate. We will file a pretreatment estimate for you electronically only at your request. Be aware that this does mean delaying treatment up to 4-6 weeks.

Any quote given by the staff of North Ave Dental Associates (verbal or written) as to the amount of the insurance reimbursement (we hope to receive) is only an estimate and is not binding to our office. You are responsible to pay the insurers portion for the services done at North Ave Dental Associates in 60 days from the time of service if unpaid by the insurer.

Remember, your employer is responsible for selecting your insurance plan, not us. If you are not satisfied with your coverage then we encourage you to notify the appropriate people at your employment.

I have read, understood, and accept responsibility for the costs of services rendered to me and my family at North Ave Dental Associates.

I am the person with legal authority to consent to treatment and billing regarding these patients and I understand the previous terms and conditions and agree to be bound by them.

Methods of Payment

Check, Cash, Credit Cards, Care Credit, Citi Health, and Lending Club

Print Name: ______________________________

Signature: __________________________________ **Date:** _______________

HIPAA Disclosure Form
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

You may refuse to sing this acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

- To conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- To obtain payment form third party payers.
- To conduct normal healthcare operations such as quality assessments and customer service.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that North Ave Dental Associates has the right to change its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) ______________________________

Relationship to Patient ______________________________

Signature ______________________________ Date ______________

How would you like us to communieate with you?

Patient Name (print) ______________________________ Date of Birth ______________

Home # ______________________ May we leave a message? Yes________ No ________

Work # ______________________ May we leave a message? Yes________ No ________

Cell # ______________________ May we leave a message? Yes________ No ________

Email # ______________________ May we leave a message? Yes________ No ________

Below please print all the names you allow information given to or received from:

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

I do not want a reminder left at all (initials) ________ I do not want a postcard sent (initials) ________

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices but was unable to do so as documented below.

Reason: ____

Initials ______________________ Date ______________________