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Patient Information

Please complete this form in ink and print your answers.
If you have any *questions, please do not hesitate to ask one of our staff.*

Name _____ Date _____
First Name MI Last Name

Address _____
City _____ State _____ Zip _____
Birthdate _____ □ Male □ Female Home Phone# (____) _____
Cell Phone# (____) _____ Work Phone# (____) _____
Where do you prefer to take calls: □ Home □ Cell □ Work
May we contact you by E-mail? □Yes □ No E-mail Address _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor
Social Security # _____ Drivers License # _____ State _____
Employer _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____
Spouse's Name _____ Workplace _____
If you are a student, name of school _____ City/State _____
How did you hear about our office? _____
Who may we thank for referring you? _____
Closest relative not living with you & their phone number _____
Emergency Contact _____ Phone# (____) _____

Responsible Party *(if patient is a minor)*

Name of person financially responsible for this account _____
Relationship to patient _____ Phone # (____)_____
Address of Employer _____
City _____ State _____ Zip _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Subscriber Birthdate _____ Subscriber Social Security # _____
Employer _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____
Insurance Co. _____ Group # _____
Subscriber ID # _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Insurance Company Phone # (____) _____

Do you have additional dental insurance? □ Yes □ No If yes, Please complete the following:
Insurance Co. _____ Group # _____
Subscriber ID # _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Insurance Company Phone # (____) _____

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Dental History

Name _____ Date _____
First Mi. Last

Reason for Today's Visit _____

Date of last exam _____ Date of last dental X-rays _____

How often do you brush? _____

What type of toothbrush do you use? □ regular □ electric

How often do you floss? _____

Do you use mouthwash or some other type of rinse? □ Yes □ No Describe _____

Do you have any dental problems now? □ Yes □ No Describe _____

_____

Have you ever had an upsetting dental experience? □ Yes □ No Describe _____

_____

Have you ever had: □ Orthodontics □ Periodontal Surgery □ Oral Surgery

Please check any of the following conditions that apply to you:

□ Bad Breath
□ Bleeding Gums
□ Clicking or Popping jaw
□ Food Collection between Teeth
□ Tired jaws in the morning
□ Difficulty in opening or closing the mouth
□ Grinding Teeth
□ Loose Teeth or Broken Filling
□ Periodontal Treatment
□ Sores or Growths in Your Mouth
□ Sore Facial Muscles
□ Sensitivity to Hot
□ Sensitivity to Cold
□ Sensitivity When Biting
□ Sensitivity to Sweets
□ Wear a Night Guard
□ Headaches or Neck Aches

□ Other:

_____

_____

Previous Dentist's Name _____

Office Address _____

City _____ State _____ Zip _____

Telephone (_____) _____

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Medical History

Patient _____

Physician _____ Date Of Last Visit _____

Please list all medications you are currently taking with dosage:

_____

_____

List all allergies:

_____

Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Indicate which of the following you have had, or have at present? (Check all that apply).

□ AIDS	□ Circulatory Problems	□ Hepatitis	□ Scarlet Fever
□ Allergies or Hives	□ Cold Sores	□ High Blood Pressure	□ Shortness of Breath
□ Anemia	□ Cortisone Treatments	□ HIV Positive	□ Sinus Problems
□ Anxiety Problmes	□ Cough, Persistent	□ Jaw Pain	□ Skin Rash
□ Arthritis, Rheumatism	□ Cough up blood	□ Kidney Trouble	□ Stroke
□ Artificial Heart Valves	□ Diabetes	□ Latex Sensitivity	□ Swelling of Feet/Ankles
□ Artificial Joints	□ Epilepsy	□ Liver Disease	□ Thyroid Problems
□ Asthma	□ Fainting	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Back Problems	□ Glaucoma	□ Neurological Problems	□ Tonsillitis
□ Blood Disease	□ Headaches	□ Pacemaker	□ Tuberculosis
□ Cancer	□ Heart Murmur	□ Psychiatric Care	□ Ulcers
□ Chemical Dependency	□ Heart problems	□ Radiation Treatment	□ Venereal Disease
□ Chemotherapy	□ Hemophilia	□ Rheumatic Fever	

□ Other: _____

_____

Please describe any positive responses from the list above:

_____

_____

Do you smoke? □ Yes □ No Describe _____

Do you use alcohol? □ Yes □ No Describe _____

Do you use recreational drugs? □ Yes □ No Describe _____

Have you had surgery or been hospitalized in the last 5 years? □ Yes □ No Describe

_____

_____

Dentist's Signature _____ Date: _____

History Review _____ History Review _____ History Review _____ History Review _____

Kimberly Smiles 1835 North Milwaukee Avenue Chicago, IL 60647 (773) 276-1047 fax: (866) 830-0746

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Consent To Treatment

Cancellation Policy:
A fee will be charged for less than 24 hours notice if cancelling an appointment.

Authorization:

If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. To the best of my knowledge, all of the preceding information is true and correct.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependents(s) to third-party insurance carriers, payors, and / or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that aren't fully covered by insurance, and I may be billed for the remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Print the name of the patient, parent, or guardian:

Printed Name: _____
First Mi. Last

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship To Patient: _____

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PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____