Family Dentistry
Welcome

1228 N Cedar Lake
Round Lake Beach, IL
847-740-8827

4725 W Fullerton Ave
Chicago, IL 60639
773-252-5757

Patient Name:_____ Sex: _____

Current Address_____ Apt:_____

City: _____ State: _____ Zip Code: _____

Social Security # _____-_____-_____ Birth Date: _____/_____/_____

Home phone _____-_____-_____ Cell phone: _____-_____-_____

Nearest relative phone _____-_____-_____ E-mail address _____

Are you a college student? ☐ Yes ☐ No Name of School _____

Spouse's Name _____ Spouse's Date of Birth: _____-_____-_____

Spouse's SS# _____-_____-_____ Spouse's cell # _____-_____-_____

I hereby authorize DM Family Dentistry to contact me at any of the above given phone numbers, address and e-mail address. _____(Initials)

Who may we thank for referring you to our office? _____

Must complete if under age 18 or a full-time student/ Responsible party information is REQUIRED

Mother's Name_____ SS# _____-_____-_____ Birthdate:_____/_____/_____

Mother's Address _____ Home Phone # _____-_____-_____

Mother's Employer _____ Work Phone # _____-_____-_____Ext. _____

Father's Name_____SS# _____-_____-_____ Birthdate: _____/_____/_____

Father's Address _____ Home Phone # _____-_____-_____

Father's Employer _____ Home Phone # _____-_____-_____

Medical Information

Is your general health good? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If yes, which ones? _____

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No if yes, for what? _____

Are you under the care of a physician? ☐ Yes ☐ No if yes, for what? _____

Physician's Name _____ Physician Phone # _____-_____-_____

Physician Address_____ Apt:_____

City: _____ State: _____ Zip Code: _____

Please list all current medications: _____

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Do you have or have you ever had any of the following?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Heart Murmur			Lupus			Hypoglycemia		
Hemophilia			Arthritis			Cancer		
Are you pregnant? How far along?			HIV or AIDS			Jaundice		
Bleeding Problems			Immunosuppresion			Stroke		
Epilepsy			Asthma			Glaucoma		
Hepatitis			Diabetes			Rheumatic fever		
Radiation Therapy			Heart Disease			TB or lung disease		
High Blood Pressure			Anemia			Hypothyroidism		
Prosthetic Joints			Ulcers			Hyperthyroidism		

Is there anything else about your health we should know? ☐ Yes ☐ No If yes, what? _____

_____

Dental Health

Purpose of today's visit _____

Date of last dental appointment _____ purpose of last dental appointment _____

Previous dentist _____ previous dentist phone # _____-_____-_____

Are your teeth sensitive to: Cold ☐ Yes ☐ No Hot: ☐ Yes ☐ No Sweets: ☐ Yes ☐ No

Do you have painful: Teeth: ☐ Yes ☐ No Gums: ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Do you floss daily? ☐ Yes ☐ No

How many times a day do you brush your teeth? _____

Do you have or have you ever had any of the following?

Problem	Yes	No	Problem	Yes	No
Tired jaw muscle?			Jaw locking/catching?		
Neck pain?			Jaw clicking/popping?		
Headache/ Facial pain?			Mouth guard/Oral splint?		
Dentures / Partial, How old are they? _____ (years, mo)			Fixed bridge? How old is it? _____ (years, mo)		
Frequent cold sores			Bleeding gums?		
Sinus problems?			Do you grind you teeth?		

Is there anything else we should know about your dental health? ☐ Yes ☐ No if yes, what? _____

I hereby testify that all the stated above is true.

X _____

Patient's signature (or guardian if patient is a minor) Date

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Financial Guidelines

Our dental practice is proud to be a team whose primary vision is to improve our patients' oral health and self-esteem through providing them with the highest quality dental care, keeping abreast of the newest dental techniques and procedures, in a pleasant and encouraging atmosphere. Any comments that you might have about our practice are appreciated, as are your referrals. In order to assist you with the investment in your dental health, we have outlined our guidelines.

Payments

Our guideline is that a payment is due in full at the time of service if the out of pocket is less than $300.00, for your convenience we accept cash, checks, money orders, credit card payments (master card, visa, American Express and Care Credit).

Patients with dental insurance

Your insurance coverage is an arrangement between your insurance company and your place of employment. There are many different policies and forms of coverage, for example, some plans cover as little as 20% of dental treatment costs, while others cover as much as 100%. Please be aware that your coverage may not be based on the current dental fee guide, the amount of coverage that has been determined by your insurance. Our staff would be happy to complete your insurance forms and mail them to your insurance company. Your insurance company will in turn send the funds directly to this office. The unpaid portion that your dental plan does not cover is your responsibility and is due after 30 days.

Cases needing outside lab work require a 50% down payment prior to being sent to the lab. The remaining will be due on the day of delivery. (An example of this would be a denture).

Collection suits

If this account if assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fee and costs of collection, including billing and postage cost._____(initials)

Need financial assistance?

We understand that dental services can become quite an investment, with or without the helping hand of an insurance company; that's why our office proudly offers payment plans for out of pockets totaling over $300.00, out of the below options, please choose your top 2 (mark 1, then 2)

_____ Payment in full before the first appointment is extended a 10% off courtesy

_____ Payment in full at the time of the first appointment is extended a 5% off courtesy

_____ Care Credit*- instant credit program, similar to those of Visa or Discover, but can ONLY be used for health treatments.*credit approval required.

_____ Dental Banc- ¼- ½ down payment and remaining balance automatically withdrawn from bank account

_____ Lay way/ pre-pay plan – No down payments required and make monthly pre-payment until the treatment is paid. No work starts until the treatment has been paid and you save 5%.

I the event that you need dental treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your health care and/or final decisions? _____If yes, please give name and relationship: _____

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Scheduling Guidelines

Cancellations

Your appointment is a reserved time especially for you, so we can offer you the highest quality treatment possible. In consideration of all of our patients who need to be treated in a timely manner we require a 48-hour cancellation notice or a charge may apply. _____(initials)

Late for an appointment

Your appointment is a time frame that we have reserved just for you. If we try to accommodate you when you're late for appointments, many other patients will be adversely affected. We do understand that sometimes events will come up to prevent you from reaching our office but we would appreciate being contacted so that another patient could have your appointment time. Our practice time is very valuable to us, as your time is very valuable to you. If you arrive more than 15 minutes late for your appointment we may ask you to reschedule this appointment. _____(initials)

Missed appointments

Again, the appointment times given to you are exclusively for you. When you do not call 48-hours before your appointment to change it and do not show up, it limits our ability to offer other patients necessary treatment. We understand that situations arise which may prevent you from making it to your appointment; that's why if you miss one appointment we may charge you up to $1.00 a minute per scheduled minute. _____(initials)

Signatures and approvals

I understand that I am financially responsible for all charges that may apply to my family and me. I fully understand and agree to the above guidelines. I was given the opportunity to ask any questions I had about the guidelines listed. I have also read and received a copy of "Notice of Privacy Practices" and also agree to it. I was given the opportunity to ask any questions I had about the guidelines listed.

X_____

Patient signature (or guardian if patient is a minor) Date

For those who have insurance

So you do not have to sign an insurance form at each visit, this dental office will maintain a "signature on file" for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any provider, insurer or other organization to release any information regarding the dental history, treatment or benefits payable for this claim of the Plan Administration or its authorized agent for the purpose of determining benefits payable, I also authorize payment directly to this dental office for services rendered.

X_____

Patient signature (or guardian if patient is a minor) Date

X_____

Witness signature (staff member) Date

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Minor authorization release

Date: _____

I hereby authorize _____ or _____

To bring my child/minor (patient's name) _____to seek dental treatment, if I am unable to personally be present. This authorization shall stay in effect until I personally request it to be removed from the file.

I might be reached at the following phone # if any questions arise during the treatment _____. If I do not answer the phone, the person bringing my child to make the appointment must make the needed decision at the time of treatment. _____ (initials)

_____
Print name of parent or guardian

_____
Signature of parent or guardian