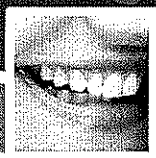
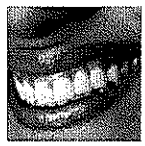
Family Dentistry of Woodstock
651 S. Eastwood Dr.
Woodstock, IL 60098

(815)338-0690


# Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Driver's License #

_____

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

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

_____

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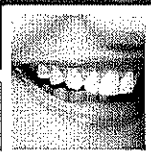
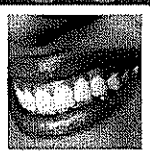


## Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber's Employer Name

_____

Subscriber's Date of Birth

_____

Insurance Company Address and Phone Number:

_____

Insurance Subscriber ID and Insurance Group Number:

_____

## Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber's Employer Name

_____

Subscriber's Date of Birth

_____

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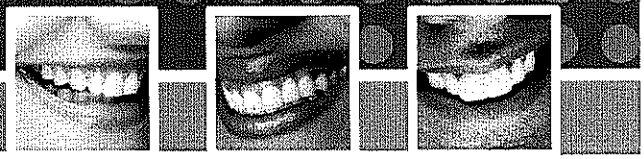

Insurance Company Address and Phone Number:

Insurance Subscriber ID and Insurance Group Number:

## Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

## Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

| | | | |
|---|---|---|---|
| ☐ *Pre-Med - Amox | ☐ *Pre-Med - Clind | ☐ *Pre-Med - Other | ☐ Allergies |
| ☐ Allergy - Aspirin | ☐ Allergy - Codeine | ☐ Allergy - Erythro | ☐ Allergy - Hay Fever |
| ☐ Allergy - Latex | ☐ Allergy - Other | ☐ Allergy - Penicillin | ☐ Allergy - Sulfa |
| ☐ Alzheimers | ☐ Anemia | ☐ Arthritis | ☐ Artificial Joints |
| ☐ Asthma | ☐ Blood Disease | ☐ Cancer | ☐ Diabetes |
| ☐ Dizziness | ☐ Epilepsy | ☐ Excessive Bleeding | ☐ Fainting |
| ☐ Glaucoma | ☐ Head Injuries | ☐ Heart Disease | ☐ Heart Murmur |
| ☐ Hepatitis | ☐ High Blood Pressure | ☐ HIV | ☐ Jaundice |
| ☐ Kidney Disease | ☐ Liver Disease | ☐ Low Blood Pressure | ☐ Mental Disorders |
| ☐ MVP | ☐ Nervous Disorders | ☐ Other | ☐ Pacemaker |
| ☐ Pregnancy | ☐ Radiation Treatment | ☐ Respiratory Problems | ☐ Rheumatic Fever |
| ☐ Rheumatism | ☐ Sinus Problems | ☐ Stomach Problems | ☐ Stroke |

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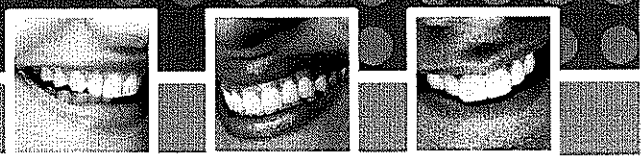

☐ Thyroid Problem ☐ Tuberculosis ☐ Tumors ☐ Ulcers
☐ Venereal Disease

☐ Ever been hospitalized (illness or injury)
☐ Taking medication for weight control (ie fen-phen)
☐ Subject to frequent headaches
☐ FEMALE: Taking birth control pills
☐ Have you ever taken Fosamax, Zometa or Aredia
☐ Presently being treated for any other illnesses
☐ Taking dietary supplements
☐ A smoker or smoked previously
☐ FEMALE: Pregnant
☐ Do you have Osteoporosis or high calcuim levels

If any conditions or alerts selected above needs further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years:

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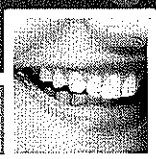
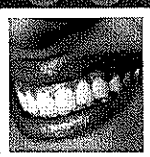


☐ By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

## Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam:

Date of most recent dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had any teeth removed
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

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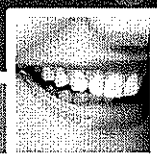
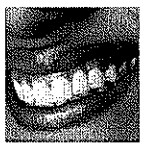




- [ ] Is there anything about the appearance of your teeth that you would like to change?
- [ ] Have you ever whitened (bleached) your teeth?
- [ ] Have you felt uncomfortable or self conscious about the appearance of your teeth?
- [ ] Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

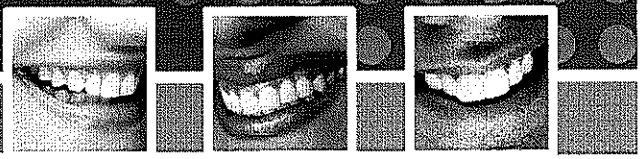
- [ ] You have problems with your jaw joint
- [ ] You have any problems chewing
- [ ] Your teeth changed in the last 5 years, become shorter, thinner, or worn
- [ ] Your teeth crowding or developing spaces
- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench you teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- [ ] You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- [ ] Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- [ ] Food gets caught between any teeth

Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family



- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

## Consent for Services and Financial Policy

Thank you for choosing Family Dentistry of Woodstock as your dental provider. We are committed to you and your treatment. We are also committed to helping you with manageable finance options for larger treatment cases. We accept Visa, MasterCard, Discover, check and cash. We request that your estimated portion of the bill be paid the day services are rendered.

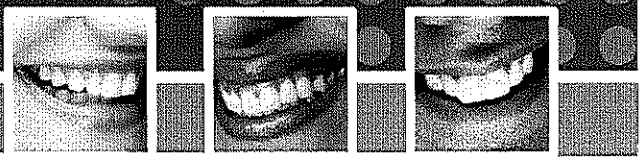
Insurance: Insurance can be a very helpful benefit for our patients. We will be happy to submit your claim to your insurance company. Sometimes for a variety of reasons an insurance company may not pay as much as expected or at all. We would recommend that in this case you contact your insurance company or human resources department for ultimately you are responsible for payment. Having more than one insurance does not mean your services will be paid 100%. Secondary insurance only pays a portion on the balance left by the primary insurance. You are responsible for any left over balances. Any balances unpaid by your insurance company will become your responsibility after forty-five days.

If you do not have insurance, payment is due at the time services are rendered unless prior financial arrangements have been made.

Divorce: This office is NOT a party to your divorce decree. Adults are responsible for their bill and minor children are the responsibility of the accompanying adult. In the case of larger treatment involving the minor child we ask that our fees be paid in full. We cannot be responsible for billing two separate parties.

Minors: Anyone under the age of eighteen must be accompanied by an adult. Any un-accompanied minors will be denied all non-emergency treatment unless permission to treat and financial arrangements have been arranged.

Missed appointments: Patients who fail their appointments without giving us a 24-hour notice will be charged $25.00. There is a $50.00 charge for all Saturday missed appointments. This fee must be paid before scheduling any other appointments.



Returned checks: There is a $25 fee for any returned checks by the bank.
Past due accounts: If your account becomes past due, we will be willing to put the remaining balance on a credit card or Capital one Health Care credit program. If the balance is not paid, your account will be turned over to a collection agency. If your account is turned over to a collection agency there will be a 33% handling charge added to your account. If your account requires a law suite to collect your balance you will be responsible for any court cost and attorney fees. We do reserve the right to charge interest to your account if it remains unpaid after 90 days. Your account will need to be paid in full before you can return to our office as soon as if falls into the past due status.
Waiver of confidentially: You understand if your account is submitted to a collection agency the fact that you received treatment at our office may become a matter of public record.
Effective date: Once you have signed your agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. Should you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to call us at (815) 338-0690. We are here to help you.
Federal and state law requires us to maintain the privacy of your health and dental information.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

## HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Please note, you may obtain a copy of the Notice of Privacy Practices at the front desk or on our website www.familydentistryofwoodstock.com

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

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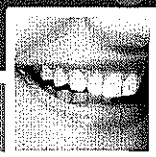

# Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

In lieu of my physical signature, I am typing my full name and last 4 digits of my social below:

*

Response Date: