

PATIENT INFORMATION

Date: _____ NEW PATIENT UPDATE

Patient: _____

LAST FIRST MI PREFERRED TITLE
 MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: _____
 PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: FULL-TIME PART-TIME
 SCHOOL/LOCATION _____

Patient Date of Birth: _____ Patient SSN: _____

ADDRESS: _____
 ADDRESS LINE 1

 ADDRESS LINE 2

CITY ST ZIP CODE

E-Mail: _____

HOME: _____
 CELL: _____
 OTHER: _____
 PAGER: _____
 FAX: _____

Referral? Yes No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____
 ADDRESS LINE 1

 ADDRESS LINE 2

WORK: _____ X
 DIRECT: _____
 OTHER: _____

INSURANCE INFORMATION

Subscriber: _____
 LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

CITY ST ZIP CODE

TEL: _____
 TEL: _____
 FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____

CITY ST ZIP CODE

Subscriber Name _____ Subscriber DOB: _____

TEL: _____
 TOLL-FREE: _____
 FAX: _____

DENTIST INFORMATION

Dentist: _____ Telephone: _____
 Clinic/Facility: _____
 Address: _____

 CITY ST ZIP CODE

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR

Date of Last Dental Visit: _____ Treatment Type: _____

- Y N Are you currently having dental discomfort? If yes, explain: _____
- Y N Any unhappy/unpleasant dental experiences? If yes, explain: _____
- Y N Any injuries to mouth/teeth/head? If yes, explain: _____
- Y N Any missing teeth other than wisdom teeth or orthodontic extractions?
- Y N Have missing teeth been replaced?
- Y N Orthodontic appliances now or in the past?
- Y N Gums bleed when brushing or flossing?
- Y N Concerned about gum disease? History of gum disease? Y N
- Y N Any concerns about the appearance of your teeth?
- Y N Does it hurt to bite or chew?
- Y N Do you clench or grind your teeth? If so, do you wear a night guard or splint? Y N
- Y N Do you want your mouth properly restored and pain free?
- Y N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Y N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
- Y N Any unusual speech habits? If yes, explain: _____
- Y N Any lost teeth? If yes, list: _____
- Y N Does the patient receive assistance with brushing and flossing? If yes, how often?

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

- Y N Under a physician's care now?
 Y N Any hospitalization in the past 5 years? _____
 Y N Any serious illnesses/surgeries? _____
 Y N Use tobacco in any form? If Yes, Type: _____
 Y N Is pre-medication required before dental visits due to heart condition or artificial joint?
 Y N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? Y N
If yes, please describe: _____

Is there anything important about your medical condition we have not asked? Y N If yes, please describe: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> RADIATION THERAPY |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> RHEUMATISM |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> COLD SORE/FEVER BLISTER | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ALZHEIMER | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> ADDICTION | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> BLOOD DISORDER | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> OTHER – PLEASE LIST: _____ | |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | | |
|---|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL | <input type="checkbox"/> DAIRY | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS | |
| <input type="checkbox"/> ACRYLIC | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS | |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ | | | | |

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | | |

DRUG NAME	DOSAGE	REASON PRESCRIBED



Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Minors must be accompanied by a parent or legal guardian.** If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
 - o All major credit cards are accepted (Visa, MasterCard, Discover)
 - o 6% Discount for our uninsured cash/check paying patients
- **Balances left over 90 days will incur an 18% or \$10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours' notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:

Date:



ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2015

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *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 operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:

Date:

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by IMPLANTWIDE,LLC (please check all that apply) :

- Cell phone: Text Message reminders permitted
- Home phone Work E-Mail:

I am granting permission for IMPLANTWIDE, LLC to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for IMPLANTWIDE, LLC to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

- Home Phone Cell Phone Work Phone None- please just ask for a call back
- Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other – please list:



IMPLANTWIDE

YOUR PARTNERS IN IMPLANT TREATMENT

WWW.IMPLANTWIDELLC.COM
Tel: 630-912-2700

1041 E WOODFIELD ROAD
SCHAUMBURG, IL 60173

PATIENT CONSENT-PAYMENT AUTHORIZATION- SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to IMPLANTWIDE, LLC of the dental benefits otherwise payable to me.

I hereby authorize IMPLANTWIDE, LLC to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:

Date: