

# Welcome!

**PATIENT INFORMATION**

Today's Date \_\_\_/\_\_\_/\_\_\_


Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Spouse's first and last name \_\_\_\_\_  
*(If minor, mother and father's first and last names)*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Email: \_\_\_\_\_@\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_



Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Work: \_\_\_\_\_ Other: \_\_\_\_\_

**We normally contact our patients between 8:00 a.m. and 7:00 p.m.  
Which number would you prefer to be called at?**

Try this number 1st:	HOME	WORK	CELL
Try this number 2nd:	HOME	WORK	CELL
Try this number 3rd:	HOME	WORK	CELL

**If you are not available at the time we contact you, may we leave dental/insurance information with another person? Please circle all that apply:**

We may leave voice mail at:

NO Yes, with: \_\_\_\_\_ HOME WORK CELL

**In the even of an emergency, whom should we contact?**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**REFERRAL**

**Whom may we thank for referring you to our office?**

Family/Friend:  
Name: \_\_\_\_\_

Walked/Passed By

Inruance Company (Booklet or online)

Internet Search

Yellow Pages (Book or online)

Other: \_\_\_\_\_

**RESPONSIBLE PARTY:**

Name of person responsible for this account \_\_\_\_\_  
(if not Patient): \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone number: \_\_\_\_\_ Birth Date : \_\_\_/\_\_\_/\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Is this person currently a patient in our office? YES NO

**INSURANCE INFORMATION-(PRIMARY INSURANCE)**

**Insurance Holder:** \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Insurance Company Name** \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

¿How much of your insurance benefit have you used this year? \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ Employer's Phone Number(\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

**INSURANCE INFORMATION-(SECONDARY INSURANCE) - Only if you are covered by more than one insurance.**

**Insurance Holder:** \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Insurance Company Name** \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

¿How much of your insurance benefit have you used this year? \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ Employer's Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

**PAYMENT OPTIONS**

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. If you have any questions about financial arrangements it will be our pleasure to assist you.

Please check the payment option that you prefer:

- Cash    Check    Visa    Master Card
- American Express    Discover
- Care Credit    Citi Healthcard:

If you prefer, we can maintain your credit card on file and transfer any balance directly to your card. If you'd like to take advantage of this option please write the information below:

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

CV Code: \_\_\_\_\_

Signature \_\_\_\_\_

**Authorization, Release, & Agreement  
to pay for services rendered**

I authorize *Elgin Dental Associates and/ or Carol Stream Dental Associates* to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to *Elgin Dental Associates and/or Carol Stream Dental Associates* all insurance benefits for myself or my dependents, otherwise payable to me.

**I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for any amount not paid by my insurance and for payments of all services rendered on my behalf or on behalf of my dependents.**

I have read, understand and agree to the office set of guidelines. I have been given the option to receive a copy of such guidelines.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient or Responsible Party

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Co-Responsible Party

## ***Our Financial Guidelines***

Thank you for choosing Elgin Dental Associates and Carol Stream Dental Associates as your dental healthcare providers. We are committed to achieving an excellent treatment outcome for you and your family. Our insurance billing specialists and financial coordinators will do their best to ensure your paperwork processed accurately and promptly filed with 3<sup>rd</sup> parties if necessary.

**Please take a moment to carefully read and understand our financial guidelines:**

### **Payment**

In order to provide you with the highest quality service while keeping our billing costs low, we require payment in full at the time of your visits. If you are applying insurance benefits, any estimated portion not covered by insurance is required to be paid in full the same day the treatment is completed.

### **Insurance and insurance collection:**

As a courtesy, we will file your dental claims and make collections from your insurance company; we will credit such collections to your account. We will collect your estimated insurance responsibility at the time of your visit, we will then bill your insurance for the remaining. Once your insurance pays their portion any remaining balances will be billed directly to you.

### **Secondary Insurance:**

Having more than one insurance Does NOT mean that your services are covered at 100%. Secondary insurances will pay as function of what your primary carrier pays. We may bill your secondary carrier as a courtesy; however, you are responsible for any balances after both insurances have made their corresponding payments.

### **Divorce Decrees:**

This office is Not a party to your divorce decree. Adult patients are responsible for their bill at the time of service.  
**The responsibility for minors' bill rests with the accompanying adult.**

### **Minor Patients:**

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, or payment by cash or check at the time of service that has been verified.

### **Missed Appointments:**

We reserve the right to charge for any missed appointments without 48 hour notice at the rate of a normal office visit (usually \$50 to \$100) Please help us serve you better by giving 48 hour notice if you need to change a scheduled appointment.

### **Record Transfer:**

We are required by law to maintain all original records of treatment in our files; however, upon request and signed release form, your records can be duplicated and transferred for a fee of \$25.00 per person.

### **Default of Payment:**

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of any agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Thank you for understanding our financial guidelines. Please let us know if you have any questions or concerns prior to signing below.

**I have read the financial guidelines mentioned above. By signing below I certify that I understand and agree to all the financial guidelines of this office.**

X \_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**

X \_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**

## Patient Privacy Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and/or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**Patient Name:** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_  
(If not patient signing)

# Child Health/Dental History Form

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>					
Phone <small>Home Work</small>			Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>		
Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? <b>If you answer yes to any of the three items above, please stop and return this form to the receptionist.</b>					
<b>Has the child had any history of, or conditions related to, any of the following:</b>					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
<b>Please list the name and phone number of the child's physician:</b>					
Name of Physician _____			Phone _____		

## Child's History

		Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... If yes, please list: _____	1.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3.	<input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____			
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized? .....	6.	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic? .....	8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?.....	9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?.....	10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?.....	11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?.....	12.	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut? .....	13.	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses? .....	14.	<input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15.	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past? .....	16.	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed? .....	17.	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth? .....	18.	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth? .....	19.	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment? .....	20.	<input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water			
22. Does the child take fluoride supplements? .....	22.	<input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used? .....	23.	<input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24.	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?.....	25.	<input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____			
27. Does child participate in active recreational activities? .....	27.	<input type="checkbox"/>	<input type="checkbox"/>

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**For completion by dentist**

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Office Use Only:**  Medical Alert  Premedication  Allergies  Anesthesia Reviewed by \_\_\_\_\_

Date \_\_\_\_\_