THE CENTER FOR
DENTAL EXCELLENCE

19615 Governors Hwy, Flossmoor, IL • tel 708-798-1234

# WELCOME...

*We're glad you are here!*

## Patient Information

| First Name: | Last Name: | Middle Initial: |
|---|---|---|
| Preferred Name: | Patient is: ☐ Policy Holder ☐ Responsible Party | |
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| Email: | ☐ I'd like to receive correspondence by Email | |
| Gender: ☐ Male ☐ Female | Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed | |
| Birth Date: | Age: | Social Security #:: |
| Emergency Contact: | Phone: | Relationship: |

## Responsible Party *(If someone other than the patient)*

| First Name: | Last Name: | Middle Initial: |
|---|---|---|
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| Birth Date: | Social Security #: | |

☐ Responsible Party is also Policy Holder for the Patient ☐ Primary Insurance Holder ☐ Secondary Insurance Holder

## Primary Insurance Information

| Name of Insured: | Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: | |
|---|---|---|
| Insured SS#: | Birth Date: | Employer: |
| Insurance Company: | | Phone Number: |

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**Dental History**

| First Name: | Last Name: | Middle Initial: |
|---|---|---|

| Reason for today's visit: | Date of last Dental Visit: |
|---|---|

| Date of Last Dental Cleaning: | Date of Last Full Mouth X-rays: |
|---|---|

Concerns about today's visit:

Have you ever been told to take a pre-medication prior to dental treatment? ☐ YES ☐ NO

**Concerns About Your Teeth**

Do you experience tooth sensitivity? ☐ YES ☐ NO ☐ SOMETIMES

Do your gums bleed or hurt? ☐ YES ☐ NO ☐ SOMETIMES

Are you a mouth breather? ☐ YES ☐ NO ☐ SOMETIMES

Do you snore or have a sleep disorder? ☐ YES ☐ NO ☐ SOMETIMES

Do you experience soreness, popping or clicking of your jaw? ☐ YES ☐ NO ☐ SOMETIMES

**Previous Dental Treatment**

Orthodontics? ☐ YES ☐ NO

Oral surgery? ☐ YES ☐ NO

Periodontal treatment? ☐ YES ☐ NO

Bite plate or mouth guard? ☐ YES ☐ NO

Serious injury to mouth or head? ☐ YES ☐ NO

**Tell Us About Your Smile**

Would you like your teeth to be whiter? ☐ YES ☐ NO

Would you like to change anything about the appearance of your teeth? ☐ YES ☐ NO

If so, what would you like to change?

So we may provide you with exceptional quality of care, we would like to get to know you better and learn what is important to you.
When you think about having dental treatment, which of the following would make you avoid having it completed?
Please check all that apply: ☐ Fear ☐ Time ☐ Budget ☐ Experiencing No Pain ☐ Lack of Trust in Dentists

At The Center for Dental Excellence, all of the following are important to us regarding your dental care.
Which one is the most important value to you regarding your dental health?
Please check one: ☐ Function *(chewing your food)* ☐ Comfort ☐ Cosmetic ☐ Keeping Your Teeth for a Lifetime

What is the most important quality you want to see in our doctors at The Center for Dental Excellence?

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**Patient Acknowledgement and Consent of Notice of Privacy Practices**

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose protected information about you and how you can get access to this information, in compliance with the Health Insurance Portability and Accountability Act of 1996 / 2013 (HIPAAP). Please request a copy of our NPP if you want detailed information on your rights and our responsibilities in protecting your information. By signing this form, you consent to our use and disclosure of protected health information about you, including in electronic form.

The patient understands that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.
- Protected health information may be disclosed or used for treatment and billing for your services. This includes communication with your doctors and insurance carriers. We will not sell or use your information for marketing or fundraising.
- The Practice has NPP and that the patient has the opportunity to obtain a copy now and a revised copy if it is changed.
- The patient has the right to request changes to the Consent in writing at any time.
- The patient has the right of confidential communication. You can provide us with specific instructions on how to contact you. Messages will be left at phone numbers provided.

**If you would like to give us permission to discuss your care with any other person please list them:**

| | |
|---|---|
| Name: | Relationship: |
| Name: | Relationship: |
| Print Name: | ☐ Patient ☐ Guardian |
| Signature: | ☐ Patient ☐ Guardian |
| Practice Witness: | Date: |

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**Medical History**

| Patient Name: | Birth Date: |
|---|---|

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| Question | | |
|---|---|---|
| Are you under a physician's care now? | ☐ YES ☐ NO | If yes, please explain: |
| Have you ever been hospitalized or had a major operation? | ☐ YES ☐ NO | If yes, please explain: |
| Have you ever had a serious head or neck injury? | ☐ YES ☐ NO | If yes, please explain: |
| Are you taking any medication, pills or drugs? | ☐ YES ☐ NO | If yes, please explain: |
| Do you take, or have you taken, Phen-Fen or Redux? | ☐ YES ☐ NO | If yes, please explain: |
| Have you every taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ☐ YES ☐ NO | If yes, please explain: |
| Are you on a special diet? | ☐ YES ☐ NO | |
| Do you use tobacco? | ☐ YES ☐ NO | |
| Do you use controlled substances? | ☐ YES ☐ NO | |

For Women

Are you: pregnant / trying to get pregnant? ☐ YES ☐ NO  Taking oral contraceptives? ☐ YES ☐ NO  Nursing? ☐ YES ☐ NO

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other  If yes, please explain:

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

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ☐ Yes ☐ No | Cortisone Medicine | ☐ Yes ☐ No | Hemophilia | ☐ Yes ☐ No | Radiation Treatments | ☐ Yes ☐ No |
| Alzheimer's Disease | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Hepatitis A | ☐ Yes ☐ No | Recent Weight Loss | ☐ Yes ☐ No |
| Anaphylaxis | ☐ Yes ☐ No | Drug Addition | ☐ Yes ☐ No | Hepatitis B or C | ☐ Yes ☐ No | Renal Dialysis | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Easily Winded | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Angina | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Rheumatism | ☐ Yes ☐ No |
| Arthritis / Gout | ☐ Yes ☐ No | Epilepsy or Seizures | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Heart Valve | ☐ Yes ☐ No | Excessive Bleeding | ☐ Yes ☐ No | Hives or Rash | ☐ Yes ☐ No | Shingles | ☐ Yes ☐ No |
| Artificial Joint | ☐ Yes ☐ No | Excessive Thirst | ☐ Yes ☐ No | Hypoglycemia | ☐ Yes ☐ No | Sickle Cell Disease | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Fainting Spells/Dizziness | ☐ Yes ☐ No | Irregular Heartbeat | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Frequent Cough | ☐ Yes ☐ No | Kidney Problems | ☐ Yes ☐ No | Spina Bifida | ☐ Yes ☐ No |
| Blood Transfusion | ☐ Yes ☐ No | Frequent Diarrhea | ☐ Yes ☐ No | Leukemia | ☐ Yes ☐ No | Stomach/Intestinal Disease | ☐ Yes ☐ No |
| Breathing Problems | ☐ Yes ☐ No | Frequent Headaches | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Bruise Easily | ☐ Yes ☐ No | Genital Herpes | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Swelling of Limbs | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Lung Disease | ☐ Yes ☐ No | Thyroid Disease | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Hay Fever | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Chest Pains | ☐ Yes ☐ No | Heart Attack/Failure | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Tumors or Growths | ☐ Yes ☐ No |
| Cold Sores/Fever Blisters | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Pain in Jaw Joints | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| Congenial Heart Disorder | ☐ Yes ☐ No | Heart Pacemaker | ☐ Yes ☐ No | Parathyroid Disease | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Convulsions | ☐ Yes ☐ No | Heart Trouble/Disease | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Yellow Jaundice | ☐ Yes ☐ No |

Have you ever had any serious illness not listed above? ☐ YES ☐ NO

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

| Signature of Patient, Parent or Guardian: | Date: |
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**Consent for Treatment**

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ______________________________ ‘s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

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 give consent to the doctors or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

| Patient's Signature: | Date: |
|---|---|
| Parent / Responsible Party Signature: | Relationship: |