

PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ **Date:** _____
First MI Last

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Email Address: _____

SS#: _____ **Date of Birth:** _____

Male ___ **Female** ___ **Married** ___ **Divorced** ___ **Single** ___ **Other** ___

Occupation: _____

Whom may we thank for referring you? _____

Emergency Contact Name: _____

Relationship: _____ **Phone #:** _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured _____ **Relationship to Patient** _____

Birth Date _____ **SS#** _____

Employer _____

Insurance Company _____

Telephone # _____

Subscriber ID# _____

Group # _____

Insurance Company Address _____

City _____ **State** _____ **Zip Code** _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured _____ **Relationship to Patient** _____

Birth Date _____ **SS#** _____

Employer _____

Insurance Company _____

Telephone # _____

Subscriber ID# _____

Group # _____

Insurance Company Address _____

City _____ **State** _____ **Zip Code** _____

PATIENT MEDICAL HISTORY

Dental health is important to one's overall health. To responsibly address your dental concerns, we need basic information regarding your health. Please answer the following questions:

Please list the medications you are currently taking:

Are you allergic to:

	YES	NO
Any antibiotics/medications.....	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____		
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Jewelry Metals (Nickel etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had:

	YES	NO	Approximate Date:
A Heart Transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
A Heart Valve Replacement/Repair Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
A Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial Joint Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
An Organ Transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer Treatment-Radiation/Chemotherapy/Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
A Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis or Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
A Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
AIDS/HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there any special medical condition we should know about? _____			

For women only:

	YES	NO	Due Date:
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you use the following:

	YES	NO	How Often:
Tobacco.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chewing Tobacco.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Dental questions, please explain:

When, approximately, was your last dental visit? _____

Do your gums bleed? _____

Do you have sensitive teeth? _____

Do you get headaches? _____

If you could change anything about your smile, what would you change?

What's the most important thing that you expect of your dentist?

My signature and date below confirm that this health questionnaire is accurate to the best of my knowledge.

Signature: _____ Date: _____

(For completion by dentist) Reviewed by: _____

Brushin' on Belmont
2007 W. Belmont Ave., 1E
Chicago, IL 60618
(773)281-9800

PATIENT HIPAA 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 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 health care 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.

Print Patient Name _____

Signature _____ Date _____

Relationship to Patient _____

Brushin' on Belmont
2007 W. Belmont Unit 1E
Chicago IL. 60618
(773) 281-9800

Acknowledgement and Consent

We'd like to take this opportunity to welcome you to our practice and to familiarize you with our office policies. Please take a moment to read the following information then sign the sheet and return it to the front desk.

Financial Policies

I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. The dental office will make every effort to give me accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not the dental office's responsibility.

I understand that I'm expected to pay what is due from me for my treatment **on the day of service**. When a child of divorce parents is seen; we will expect payment from whichever parent accompanies the child to their visit. If any balance remains after my insurance company has paid a claim, I will receive a statement from dental office for this, and I am expected to pay in full within **15 days** of receiving the statement.

I agree to be responsible for timely payments for all services rendered on my behalf or my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policies. I understand that if my account is past due, a **1.5% monthly** (18% APR) interest charge will be applied to my account.

I understand that if my account is not paid as agreed, the account will become delinquent and will be transferred to an outside collection agency. If this becomes necessary, additional fees may be added to cover handling charges.

I understand that my account will be charged a **\$50.00** fee for any dishonored check and that I must immediately pick up the check and pay the amount **in cash** including any fees.

Appointment Cancellation Policy

At Brushin' on Belmont, appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. We, therefore, require at least **48 hours** notice prior to canceling or rescheduling appointments.

Patients, who cancel or reschedule their appointment without a proper notice, will be charged a cancellation fee of **\$50.00 per hour of scheduled appointment**.

If two broken /missed appointments or cancellations occur without proper notice, the office reserves the right to **NOT** schedule any subsequent appointments and advise the patient to seek an alternate dental provider.

We thank you in advance for your cooperation with our administrative policies.

I acknowledge that I have been informed and given a copy of the Financial and Cancellation policy for the office of Brushin' on Belmont.

Signature of Patient (or parent/guardian if a minor)

Date