



Today's Date: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

If minor, Parents' names: \_\_\_\_\_

## Responsible Party \*\*\*\*

(Leave Blank if Same as Above)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

## Insurance Information

**Dental Ins. Co.:** \_\_\_\_\_ **Employer** \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN: \_\_\_\_\_

Group#: \_\_\_\_\_ Policy#: \_\_\_\_\_

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of my dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signed: \_\_\_\_\_

In Emergency Call: \_\_\_\_\_ Phone#: \_\_\_\_\_

(name of close relative  
not living in your home)

Who may we thank for your referral? \_\_\_\_\_

Chart Forms - Registration forms - Amazing Smiles.doc

\*\*\*In cases of divorce - parent who escorts child to office is financially responsible for the child (regardless of divorce agreements)

## FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is **due at the time services are rendered** unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Discover, American Express, Master Card or Visa. We will be happy to process your insurance claim form for your reimbursement. We will accept the assignment of benefits which means we will accept the payment directly from your insurance company. However, in order to do this, you must pay for the portion not covered at the time of service. Please bring your policy booklet which explains your dental benefits so that we may determine the amount covered.

Returned checks and balances older than 30 days may be subject to additional collection fees, court costs including attorney fees, and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments canceled without 24 hour advance notice. Any account balances more than 30 days past due are subject to a billing charge of 1.5% per month on the unpaid balance. If we refer your account to our attorney for collection, **a collection fee equal to 40% of your balance** will be added, and you will also be responsible for any fees incurred as a result of the collection process.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. *Your insurance is a contract between you, your employer and the insurance company.* We are not a party to the contract. When we accept assignment of benefits, it is a courtesy extended to you.
2. Our fees are generally considered to fall within the acceptable range by most companies qualifying them to be covered for the maximum allowance determined by each carrier. This applies only to policies which pay a percentage (for example, 50% or 80%) of usual customary and reasonable fees for this region ("UCR"). "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus our fees are considered Usual, Customary, and Reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule of benefits", which bears no relationship to the current standard and cost of care in this area.
3. *Not all services are covered benefits in all contracts.* Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect the 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.

We participate in the Delta Dental Insurance PPO and Cigna PPO in our Homer Glen office ONLY.

If you have any uncertainty regarding insurance coverage, please do not hesitate to ask us. **Our primary concern is to provide you the highest quality dental care.**

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. My signature will also verify that I agree to allow a direct transfer of funds from my checking account for any unpaid balance through FeeCertain. I have read all the information contained in these registration forms and have completed the answers to the best of my knowledge. I certify that this information is true and correct to the best of my knowledge. I will notify the doctor of any changes in my health status or any information included in these registration forms.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. We are required by federal and state law to maintain the privacy of your health information. We may use or disclose your health information for such reasons listed below: Another health care provider treating you, to obtain payment for services rendered, in connection with our healthcare operations, in reasonably suspected abuse or neglect cases, national security and for appointment reminders. You have the right to access, amend, request a disclosure accounting, and request alternative communications regarding your health information. All must be in writing. You are entitled to receive this notice in written form.

I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of Amazing Smiles Family Dental Care staff or our doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration.

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Signature

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Date

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Parent (if minor)

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Date

# Health Questionnaire

Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Name of Physican: \_\_\_\_\_ Phone: \_\_\_\_\_

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. We hate filling out forms as much as you do, but this information is very important. Thank you in advance for your cooperation.

**Please circle Yes or No**

1. Yes No Have you been under the care of a physician in the past 2 years?
2. Yes No Have you had a recent illness or surgery?
3. Yes No Have you ever been hospitalized?
4. Yes No WOMEN: Are you pregnant?

**\*\*\*Periodontal infections can increase the risk for low birth weights in newborns. This is very dangerous!**

**HAVE YOU EVER HAD OR DO YOU HAVE?**

5. Yes No Heart trouble or heart surgery

**\*\*\*Periodontal Disease and Dental Infections may increase the risk of Stroke and Coronary Heart Disease**

6. Yes No Pains in the chest or shortness of breath
7. Yes No High blood pressure today's B.P.: \_\_\_\_\_ / \_\_\_\_\_
8. Yes No Stroke
9. Yes No Rheumatic fever or heart murmur Do you require antibiotic pre-medication? \_\_\_\_\_
10. Yes No Anemia or other blood disorders
11. Yes No Thyroid trouble
12. Yes No Jaundice, Hepatitis or other liver troubles
13. Yes No Diabetes

**\*\*\*Recent studies have shown a link between Diabetes and Periodontal Disease. It is important to your health that they both be under control. The warning signs of Diabetes are frequent trips to the bathroom, constant thirst, and always feeling hungry.**

14. Yes No Any breathing problems (Hay fever, Asthma, Tuberculosis, Emphysema)
15. Yes No Stomach or intestinal problems
16. Yes No Kidney or bladder problems
17. Yes No Cancer or Tumors
18. Yes No Convulsions, seizures, or fainting
19. Yes No Abnormal or prolonged bleeding
20. Yes No Syphilis, Gonorrhea, Oral Herpes or AIDS
21. Yes No Arthritis, bone disease, joint problems, joint replacement or joint implants
22. Yes No Eye problems (Glaucoma, Retinal repair, etc.)
23. Yes No Problems with alcohol or drug abuse
24. Yes No Lumps in your neck, armpits or groin
25. Yes No Recent appearance of discolored areas in your mouth or other areas
26. Yes No Mental illness
27. Yes No Any other medical condition that we should be aware of

**ARE YOU TAKING OR HAVE YOU TAKEN WITHIN THE LAST 2 YEARS:**

28. Yes No Cortisone, Steroids or ant-rejection drugs
29. Yes No Blood thinners (Coumadin, Warfarin, Heparin)
30. Yes No Tranquilizers, sedatives or pain drugs (incl. aspirin)
31. Yes No X-ray or radiation treatment for cancer
32. Yes No Chemotherapy for cancer
33. Yes No Nitroglycerine or other heart medications
34. Yes No Birth control pills

**\*\*\*Antibiotics can interfere with birth control pills by causing them not to work.**

35. Yes No Any other medicine or drugs

**HAVE YOU EVER HAD A REACTION OR ALLERGY (ITCHING, RASH OR SWELLING) TO:**

36. Yes No Local anesthetics (Novocaine, Xylocaine, Etc.)
37. Yes No Penicillin or other antibiotics
38. Yes No Latex or metal (Please specify) \_\_\_\_\_

## Dental History

### Tell us about your past dental experiences:

1. Yes No Have you ever had an unfavorable experience in the dental office?
2. Yes No Was the staff of your previous dental office unfriendly?
3. Yes No Were the fees clearly explained before the procedures?
4. Yes No Is there anything you can suggest that we can improve on your past experiences? \_\_\_\_\_
5. Yes No Have you ever had dental surgical treatment?
6. Yes No Have you ever had periodontal (gum) treatment?

### Tell us about some of your symptoms:

7. Yes No Are any of your teeth sensitive to temperature extremes, toothbrushing or chewing pressure?
8. Yes No Do your gums bleed while brushing or flossing?
9. Yes No Have you had any head, neck or jaw injuries?
10. Yes No Do you have any pain or soreness in your neck area?
11. Yes No Are you aware of clenching or grinding your teeth while awake or sleeping?
12. Yes No Does your jaw click or pop while eating or yawning?
13. Yes No Do you have frequent headaches?
14. Yes No Do you use tobacco in any form? Type and frequency: \_\_\_\_\_

### Do you have any cosmetic concerns:

15. Yes No Are you dissatisfied with the appearance of your teeth?
16. Yes No Are you dissatisfied with the color of your teeth?
17. Yes No Would you like a whiter smile?
18. Yes No Would you like straighter teeth?
19. Yes No Would you be interested in invisible braces?

When was the last time you were treated in a dental office? \_\_\_\_\_

What was your complaint or the treatment rendered at that time? \_\_\_\_\_

\_\_\_\_\_

What is your chief complaint or reason for seeing the Dentist today? \_\_\_\_\_

\_\_\_\_\_

Would you like to discuss cosmetic concerns about your teeth? \_\_\_\_\_

If Yes, what specific concerns do you have? \_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Dentist at the next appointment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Our practice is dedicated to your quality care and is pleased to reserve this time for you. In order to contain costs, guidelines have been established regarding appointment scheduling. Many patients need our services and missed appointments inconvenience everyone. So that we may provide care to all of our patients, we require a minimum of 48 hour notice for appointment changes. A charge will be applied for broken and missed appointments without advanced notification. Thank you for your cooperation in this matter.**

# Consent for Use and Disclosure of Health Information

## Pt giving consent

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

**TO THE PATIENT:** PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**PURPOSE OF CONSENT:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our NOTICE OF PRIVACY PRACTICES before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our NOTICE OF PRIVACY PRACTICES. If we change our privacy practices, we will issue a revised NOTICE OF PRIVACY PRACTICES, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our NOTICE OF PRIVACY PRACTICES, including any revisions of our notice, at any time by contacting:

Pam Janus or Nadine Swierczewski at: 16906 Oak Park Ave.  
Tinley Park, IL. 60477  
(708) 444-7645  
(708) 381-5450 fax

**RIGHT TO REVOKE:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

## Signature

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of this consent form and your NOTICE OF PRIVACY PRACTICES. I understand that, by signing this consent form, I am giving my consent to your use and disclose of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

If the consent is signed by a personal representative on behalf of the patient, complete the following:

Name \_\_\_\_\_

Relationship to the patient \_\_\_\_\_