DENTAL CARE OF LOMBARD

FAMILY-FOCUSED DENTISTRY

PATIENT INFORMATION

Please Print

Patient Information

Circle One: Dr/ Mr/ Mrs / Miss Marital Status (circle): Single Married Minor

First: _____ Middle: _____ Last: _____

Street: _____ Unit:_____ City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ May we contact you by email? (circle): Yes No

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex: (circle): M F

Emergency Contact: _____ Phone: _____

Responsible Party (if someone other than patient)

Circle One: Dr/ Mr/ Mrs / Miss

First: _____ Middle: _____ Last: _____

Street: _____ Unit:_____ City: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Responsible Party's Social Security Number: _____ Date of Birth: _____ Sex: (circle): M F

How did you hear about us?

○ Internet ○ Yelp ○ Facebook ○ Mailer ○ Drove by ○ Referral (Name: _____) ○ Other: _____

Insurance Information

Do you have Dental Insurance? (circle): Yes No Do you have Secondary Dental Insurance? (circle): Yes No

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber ID or SSN		Subscriber ID or SSN	
Subscriber Date of Birth		Subscriber Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card and photo ID to our front desk to be scanned into your chart			

Health Information

Patient Name: _____ Email: _____

Here at Lombard Dental Care we take your oral health very seriously. Before we start your visit, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Physician's Name & Phone #: _____ Have you been under the care of a physician? (circle): Yes No

Have you ever been hospitalized? (circle): Yes No

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle): Yes No

List any medications you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs and vitamins:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Circulatory Problems			High Blood Pressure			Thyroid Problems		
Allergies or Hives			Cold Sores			Kidney Trouble			Tobacco Use		
Anemia			Cortisone Treatments			Liver Disease			Tonsillitis		
Anxiety Problems			Cough, Persistent			Mitral Valve Prolapse			Tuberculosis		
Arthritis/Rheumatism			Diabetes			Neurological Problems			Ulcers		
Artificial Joints			Epilepsy			Pacemaker					
Asthma			Fainting			Radiation Treatment					
Back Problems			Glaucoma			Rheumatic Fever					
Blood Disease			Headaches			Scarlet Fever			Other Disease or Illness:		
Cancer			Heart Murmur			Sinus Problems					
Chemical Dependency			Heart Problems			Stroke					
Chemotherapy			Hepatitis			Swelling of Feet/Ankles					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

Reason for today's visit?: _____

Date of last dental exam: _____ Date of last dental cleaning: _____ Date of last dental x-rays: _____

How often do you brush?: _____ How often do you floss?: _____

Do you have any dental concerns at this time? _____

Have you ever had: ○ Orthodontics ○ Periodontal Surgery ○ Oral Surgery ○ Dental Implants

Have you taken antibiotics prior to dental procedures in the past? (circle): Yes No

Would you change anything about your smile?_____

Please check all that apply:	Y	N		Y	N		Y	N		Y	N
Bad Breath			Grinding Teeth			Sensitivity (sweets, hot/cold)			Sore jaw in the morning		
Bleeding Gums			Loose or Fractured Teeth			Difficulty in opening/closing			Sore Facial Muscles		
Clicking/Popping Jaw			Periodontal Disease			Wear a Night Guard			Sensitivity when biting		
Food collection between teeth			Sores or Growths in mouth			Snoring			Dry mouth		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____

Patient HIPAA & Financial Consent

Patient HIPAA Consent

I understand that as part of my heathcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care. I give permission for Dental Care of Lombard to email my xrays, photos and treatment plan to dental specialists as needed.
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Financial Policies

Financial Policy

Payments are expected in full at the time services are rendered; this includes any estimated copayments from patients with dental insurance. For your convenience, we accept: cash, Visa, Mastercard, Discover and American Express.
For dental care requiring more than one visit, payments can be made during the course of care as each service is rendered. Monthly billing is available through CareCredit.

If you will be using dental insurance, we will be happy to file a claim to your insurance as a courtesy to you, but please remember that it is a contract between you and your insurance company. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility and what they will cover and you are responsible for the remaining portion. After 90 days, any portions not paid by your insurance provider become your responsibility. In the event payments are not received, the practice may refer the unpaid balance to a collection agency.

Missed Appointment Policy

Your appointment is reserved specifically for you. If you must make changes to your appointment, please give us a minimum of 24 hour notice to avoid any cancellation fees. Last minute appointment cancellations or failed appointments will result in a $50.00 fee.

Authorization

I authorize Dental Care of Lombard to leave necessary messages at my home, mobile, and/or workplace phone numbers.

I authorize payments from my insurance carrier to be submitted directly to Dental Care of Lombard.

I agree to be financially responsible for payment of all my services rendered on my behalf or on behalf of my dependents.

Print Patient Name: _____ Date: _____

Patient or Guardian Signature: _____