PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

(PLEASE PRINT)

NAME _____ (FIRST MI LAST)

BIRTHDATE _____

HOME PHONE ____

ADDRESS _____

CITY _____

STATE/PROV. ___ ZIP/P.C. ___

E,MAIL _____

CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIYORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____

WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. ___

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____

WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL /COLLEGE _____

CITY ____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E,MAIL _____ CELL PHONE _____

DRIVER'$ LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED ____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. ___ ZIP/P.C. ___

INSURANCE COMPANY _____ GROUP#____ UNION OR LOCAL # ___

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. ___ ZIP/P.C. ___

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAYE YOU USED? _____ MAX. ANNUAL BENEFIT? __

DO YOU HAYE ANY ADDITIONAL INSURANCE? O YES O NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED ____

NAME OF EMPLOYER _____ WORK PHONE ____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. ___ ZIP/P.C. ___

INSURANCE COMPANY _____ GROUP #____ UNION OR LOCAL # ___

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. ___ ZIP/P.C. ___

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAYE YOU USED? _____ MAX. ANNUAL BENEFIT? __

SIGNATURE

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E,MAIL _____ CELL PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	O	O
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	O	O
}. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON,PRESCRIPTION MEDICINE?	O	O
IF YES, WHAT MEDICATION(S) ARE YOU TAKING?_____		
4. HAVE YOU EVER TAKEN FEN,PHEN/REDUX?	O	O
5. DO YOU USE TOBACCO?	O	O
b. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	O	O
7. ARE YOU WEARING CONTACT LENSES?	O	O

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
O	O	LOCAL ANESTHETICS (E.G. NOVOCAINE)	O	O	BARBITURATES	O	O	ASPIRIN
O	O	PENICILLIN OR OTHER ANTIBIOTICS	O	O	SEDATIVES	O	O	OTHER _____
O	O	SULFA DRUGS	O	O	IODINE			_____

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN } WEEKS)?	O	O
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	Q	O
B) ARE YOU NURSING?	0	O
C) ARE YOU TAKING BIRTH CONTROL PILLS?	O	O

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
O	O	HIGH BLOOD PRESSURE	D	O	HEART DISEASE	O	O	CHEST PAINS
O	O	HEART ATTACK	O	O	CARDIAC PACEMAKER	O	O	EASILY WINDED
O	O	RHEUMATIC FEVER	O	O	HEART MURMUR	O	O	STROKE
O	O	SWOLLEN ANKLES	O	O	ANGINA	O	O	HAY FEVER / ALLERGIES
O	O	FAINTING / SEIZURES	O	O	FRE0UENTLY TIRED	O	O	TUBERCULOSIS
O	O	ASTHMA	O	O	ANEMIA	O	O	RADIATION THERAPY
O	O	LOW BLOOD PRESSURE	O	O	EMPHYSEMA	D	O	GLAUCOMA
O	O	EPILEPSY / CONVULSIONS	O	0	CANCER	O	O	RECENT WEIGHT LOSS
O	O	LEUKEMIA	O	O	ARTHRITIS	O	O	LIVER DISEASE
O	O	DIABETES	O	O	JOINT REPLACEMENT OR IMPLANT	O	O	HEART TROUBLE
O	O	KIDNEY DISEASES	D	O	HEPATITIS / JAUNDICE	O	O	RESPIRATORY PROBLEMS
O	O	AIDS OR HIV INFECTION	O	O	SEXUALLY mANSMITTED DISEASE	O	O	OTHER _____
D	O	THYROID PROBLEM	O	O	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____

_____

_____

_____

_____

SIGNATUIIE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	O	O
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LI0UIDS/FOODS?	O	O
}. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIOUIDS/FOODS?	O	O
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	O	O
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	O	O
b. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	O	O
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	O	O
B) PAIN (JOINT, EAR, SIDE OF FACE)?	O	O
C) DIFFICULTY IN OPENING OR CLOSING?	O	O
D) DIFFICULTY IN CHEWING?	O	O

	YES	NO
8. DO YOU HAVE FRE0UENT HEADACHES?	O	O
9. DO YOU CLENCH OR GRIND YOUR TEETH?	O	O
10. DO YOU BITE YOUR UPS OR CHEEKS FRE0UENTLY?	O	O
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	O	O
12. HAVE YOU HAD ANY ORTHODONTIC	O	O
1}, HAVE YOU EVER HAD PROLONGED FOLLOWING EXTRACTIONS?	O	O
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	O	O
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	O	O

SIGNATURE

I CERTIFY THAT I HAVE IIEAD AND UNDEIISTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE OUESTIONS HAVE BEEN ACCUIIAIELY ANSWEIIED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEIIOUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

Des Plaines Dental Studio

Please Review the medication list and let us know I you are taking or have taken any of the following medications:

YES	NO	
☐	☐	ACTONEL- Risedronate
☐	☐	BONIVIA - Ibandronate
☐	☐	BONEFOF - Clodronate
☐	☐	ZOM ETA - Zoledronate
☐	☐	FOSAMAX-Aledronate
☐	☐	AREDIA- Pamidromate
☐	☐	Chemotherapy treatment for cancer

Taking these medications was linked to serious complications following invasive dental treatment procedures like extractions, periodontal surgery and deep cleaning.

Signature_____ date ____ _

DES PLAINES DENTAL STUDIO
INFORMED CONSENT FOR GENERAL
DENTAL TREATMENT

I understand the purpose of this consent is to raise my awareness of risks that are common-place in many <lenta] procedures. I understand that I have the right to accept or reject dental treatment recommended.

DRUGS AND MEDICATIONS

I understand that analgesics, antibiotics and other medications used in <lenta! offices can cause allergic reactions, not limited to redness, pai n, itching, swelling of tissue, vomiting and/or anaphylactic allergic reaction, drowsiness, Jack of awareness and coordination. I understand that the use of dental analgesics can cause localized mouth and face paresthesia (numbness) that may be temporary or permanent. If you are a woman on birth control medication you must consider the fact that antibiotics rnight make orał birth control less effective and increase chances of pregnancy.

EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the treatment plan that will be discussed with me during my appointment.

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the !ower jaw (near the ear) subsequent to routine <lenta! treatment
wherein the mouth is held in the open position. Although symptoms of TMD

FILLINGS

I understand that amore extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, or post and core with crown, or both. I understand that care rnust be exercised in chewing on fillings during the

first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

CROWNS, BRIDGES, VENEERS AND BONDING

I understand that sometimes it is not possible to match the color of natura] teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

DENTURES - COMPLETE OR PARTIAL

I realize that full or partia! dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first.

Immediate dentures rnay require severa! adjustrnents and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee.

I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of rnore than 30 days, there will be additional charges.

ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal materiał may extend through the root tip which does not necessarily affect the success of the treatment. The tooth rnay be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the mai n reasons root canals fai I Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth.

I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Name (printed): _____

Signature: _____ Date: _____

Witness: _____

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Jnsurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA JNFORMATION FORM and any subsequent changes in office policy. Tunderstancl that this consent shall remain in force from this time forward.

Signature _____ Relationship to patient _____

Patient Financial Responsibility Agreement

Thank you for choosing Des Plaines Dental Studio for your treatment needs. To ensure clarity and transparency, we ask that you carefully review and sign this Financial Agreement before proceeding with treatment.

Payment Processing and Patient Deposit

A deposit equal to one-third (1/3) of the total treatment cost is required at the first treatment appointment. The remaining balance will be divided into payments over a number of visits. If other finance arrangements are needed, we accept CareCredit and other major credit cards including Visa, Mastercard,, American Express, and Discover. We also accept Zelle payment and Paypal credit and debit cards.

No-Show and Late Cancellations

When we schedule your appointment, this time is reserved exclusively for you. When you fail to notify us of your inability to keep the appointment, another patient in need of dentistry is unable to receive treatment. We request that you give a 48 hour notice when you realize you cannot keep an appointment. A cancellation fee of $80 per scheduled appointment will be assessed for appointments broken with less than 48 hours' notice.

Insurance

If you have dental insurance, we will submit claims on your behalf. However, you are responsible for any portion not covered by your insurance. We cannot guarantee that insurance coverage since eligibility and benefits are determined by your individual insurance plan. If the insurance claim is denied or only partially covered, you are responsible and agree to pay the remaining balance.

Agreement and Signature

By signing this agreement, you acknowledge that you understand and accept the financial terms outlined above. You agree to make all payments as specified and understand that failure to do so may result in additional fees, account suspension, or referral to a collection agency.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Patient Signature: _____

Date: _____