



800 Biesterfield Rd, Ste #660
Elk Grove Village, IL 60007
Phone: (847) 437-3250
Fax: (877) 748-3544
elkgrovesmilecenter@gmail.com
www.ElkGroveSmileCenter.com

WELCOME! PLEASE INTRODUCE YOURSELF

Name: _____ Birth Date: ___/___/___ Age: ___ Sex: ___ SSN: ___-___-___
Home Address: _____
Street City State Zip
Home Phone: (____) _____ - ___ Cell Phone: (____) _____ Email Address: _____
Preferred Method of Contact to Confirm Dental Appointments: Phone ___ Email ___ Text ___
How did you hear about us: Google Search ___ YELP ___ Bing Search ___ Insurance List ___ Facebook ___ Postcard ___
Patient Referral (list Patient's name) _____ Other _____
Employer: _____ Occupation: _____ Work Phone: (____) _____
Married: Yes ___ No ___ Spouse's Name: _____ Birth Date: ___/___/___ Sex: ___ SSN: ___-___-___
Person Responsible for Account: _____
In Case of Emergency, please contact: _____ Phone: (____) _____

DENTAL INSURANCE

Insured Person's Name: _____ Birth Date: ___/___/___ SSN: ___-___-___
Name of Insurance Company: _____ Subscriber ID or Member ID: _____
Address: _____ Group or Policy # _____
Street City State Zip
Does your Spouse have separate dental insurance: Yes ___ No ___ If Yes, does this Insurance Cover You Also: Yes ___ No ___
Secondary Insured Person's Name: _____
Name of Insurance Company: _____
Address: _____ Group or Policy # _____
Street City State Zip

Our office will be glad to fill out and submit your insurance forms as a courtesy to you. However, it is the ultimate responsibility of the patient to pay for this account.

- I give my permission to you to call me to discuss matters related to this form.
- We kindly request that **at least 48 hours** advance notice be given to cancel your appointment.
- I have read the above conditions and I agree with them.

Signature: _____ Date: _____

DENTAL HISTORY

Previous Dentist: _____ Phone: (____) _____

Date of Last Dental Visit (exam or treatment): _____ Date of Last X-rays: _____

Have you ever been treated for any of the following:

Endodontics (root canals) _____	Dentures/Partial Dentures _____
Orthodontics (braces) _____	Oral Surgery (extractions) _____
Periodontics (gum surgery) _____	Implants _____
Bridges or Crowns _____	Cosmetic Dentistry (whitening, veneers, etc) _____

Have you ever had an Injury or Trauma to the Face or Jaw: _____

Have you ever had TMJ (jaw joint) problems/clicking/tenderness: _____ Last Time you had this issue: _____

Are you currently having any problems with any of the following:

Temperature Sensitivity (hot/cold) _____	Bad Breath (halitosis) _____
Pressure Sensitivity (on biting or chewing) _____	Food Impaction _____
Tender or Bleeding Gums _____	Clenching/Grinding _____
Snoring _____	Other _____

MEDICAL HISTORY

Name of Physician or Clinic: _____ Phone: (____) _____

How would you describe your general health: Good ___ Fair ___ Poor ___

When did you last see your Physician: _____ For what Condition: _____

Have you had a major illness or been hospitalized within the last 5 years? Yes ___ No ___ Explain: _____

Please list any medications or drugs you are currently taking: _____

Please check if you are sensitive to or had a reaction to the following:

Penicillin ___	Novocaine/Lidocaine (Local anesthetic) ___	Aspirin ___
Other Antibiotics ___	Codeine ___	Demerol ___
Sulfa Drugs ___	Barbiturates (sleeping pills, sedatives) ___	Latex ___
Other: _____		

Do you Smoke or use Tobacco? Yes ___ No ___ How long and how much per day? _____

Have you ever been told you need to pre-medicate for a dental appointment? Yes ___ No ___

Have you ever had any of the following:

Abnormal Blood Pressure (High/Low).....	Yes No	Excessive Bleeding.....	Yes No
HIV or AIDS.....	Yes No	Eye Diseases (glaucoma, cataracts)	Yes No
Allergies (Hay fever, etc).....	Yes No	Rheumatic Fever or Heart Disease.....	Yes No
Anemia.....	Yes No	Heart murmur.....	Yes No
Angina (chest pains).....	Yes No	Stroke.....	Yes No
Pacemaker or Artificial Heart Valve.....	Yes No	Severe or Frequent Headaches.....	Yes No
Arthritis.....	Yes No	Herpes, Cold Sores, Fever Blisters.....	Yes No
Hepatitis, Jaundice, Liver Disease.....	Yes No	Blood Transfusions.....	Yes No
Respiratory Condition (TB, Asthma, Emphysema...)	Yes No	Cancer, Tumors, Malignancies.....	Yes No
Joint Replacement (Hip, Knee, etc).....	Yes No	Kidney Disease or Disorder.....	Yes No
Skin Disease.....	Yes No	Thyroid Condition (hyper/hypo).....	Yes No
Congenital Heart Defects.....	Yes No	Diabetes.....	Yes No
Epilepsy/ Seizures.....	Yes No	Psychiatric Treatment.....	Yes No
Ulcers.....	Yes No	Heart Surgery.....	Yes No
Venereal Disease (Syphilis, Gonorrhea).....	Yes No	Parkinson's Disease.....	Yes No
GERD (Esophageal Reflux).....	Yes No		

Is there any other information about your health we should know? _____

WOMEN ONLY: Are you pregnant? Yes ___ No ___ Expected Delivery Date: _____

Are you taking Oral Contraceptives? Yes ___ No ___

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR SIGNATURE: _____ DATE: _____

CUSTOMIZING YOUR TREATMENT

I am most interested in:

___ Cosmetic Options	___ Maintaining General Oral Health	___ Children's Dentistry
___ Whitening	___ Invisalign (Clear Braces)	___ Controlling Gum Disease
___ Implants	___ Dentures	Other: _____

Please share your Hobbies or Interests with us: _____

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us **at least 48 hours** notice. This courtesy makes it possible to give your reserved room to another patient who may need it.

There is a charge of \$75 for not showing up for scheduled appointments without giving at least 48 hours notice.

Repeated cancellations or missed appointments will result in loss of appointment privileges; a \$150 non-refundable fee will be required to secure future appointment times.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Financial Policy

Payment is due at time of service on the day the procedure is started. Payment plans can be set up, but must be set up in advance.

Patient's with insurance: patient's estimated copay is due at time of service and the rest will be billed to the insurance company. Any remaining balance will be the patient's responsibility.

I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

I agree to pay all related fees, attorney fees and court costs in any attempts to recover unpaid balances over 90 days. A 25% fee will be added to any account sent to collections or to an attorney or seen in small claims court.

Patient/Guardian Signature _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

