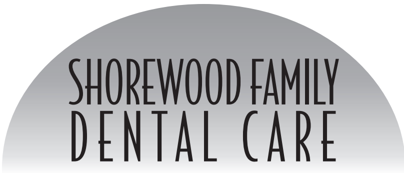

PATIENT MEDICAL HISTORY

Today's Date: ______________________________

Patient's Name: ______________________________

Preferred Name: ______________________________

Address: ______________________________

City: ______________________ State: __________ Zip: __________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Email: ____________________

Birth Date: __________ Social Security No: __________ Marital Status: __________

Primary Dental Guarantor: ____________________ Phone: ____________________

Secondary Dental Guarantor: ____________________ Phone: ____________________

Physician Name: ____________________ Phone: ____________________

Do you smoke or use tobacco? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

If female please answer the following:
Are you taking Birth Control Pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No If Yes, number of weeks: __________
Are you nursing? ☐ Yes ☐ No

Check conditions that apply:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Bones
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer- Chemotherapy
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Cough
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ HIV+ AIDS
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Taken Fen-Phen
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Other: ____________________

____

____

Check any allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other: ____________________

____

____

List all medications: ______________________________

Is there any disease, condition or problem that this office should know about that is not covered above?

☐ Yes ☐ No

If yes, please describe: ______________________________

Notes: ______________________________

Who may we thank for referring you?: ______________________________

Signature: ______________________________ Date: ______________

(If Under 18, Parent or Guardian Signature Required):

CONSENT

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

I authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connect with (Name of Patient) ________________________________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided at Shorewood Family Dental Care for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I understand that Shorewood Family Dental Care has a cancellation policy of $50 for any appointments that are failed or have not been cancelled within 24 hours prior to the appointment.

I understand that any treatment plan gone over with me, if insurance is involved, is an estimate only.

Patient Signature:____________________________________ Date:_________________________

If Under 18, Parent or Guardian Signature Required: ____________________________________

Shorewood Family Dental Care

(815) 725-5991 (phone) 607 W. Jefferson St.
(815) 744-4734 (fax) Shorewood, IL 60404

CONSENT FORM

It is your dentist's responsibility to recommend what you need. All recommendations are based on diagnostic (x-rays) and clinical pictures and presented to you by the dentist. We will give you options (if any) for the treatment recommended, answer all questions you might have about it and will help you to decide what treatment would be the best for you. A Treatment Coordinator will go over any financial arrangements with you as needed.

When your office visit is completed, you will be asked to pay an estimated amount for the service provided. Our estimate is a guess based on the information provided by the insurance representative over the phone. The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible to know your Plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as a missing tooth, crown/ bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exams, prophylaxis, fluoride and x-rays etc.

The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, or Discover. To help you accept an extensive treatment plan, we are offering a CareCredit dental treatment Financing Program.

All estimates are subject to final approval by your dental insurance plan; therefore the amount due is subject to change after final explanation of benefits have been paid.

FINANCIAL CHARGES: All returned checks are subject to a $25 fee. All balances over 60 days are subject to interest in the amount of 1.5 % per month mandated by State law

PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.

MISSED APPOINTMENT FEE: Please note that there is a missed appointment fee of $50.00 for all appointments not given at least 24 business hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment.

This is an Agreement between **Shorewood Family Dental Care**, as a provider of professional services, and the Patient named on this form. By reading and signing this Agreement, you are agreeing and accepting this Policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF SHOREWOOD FAMILY DENTAL CARE.

PRINT NAME OF PATIENT(S) ____

SIGNATURE OF RESPONSIBLE PARTY ______________________________ **DATE** ____________

Patient Name:____

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to **Shorewood Family Dental Care** to disclose and discuss any information related to my dental treatment with the following family member(s), other relative(s) and/or close personal friend(s):

Name:_______________________________________Relationship:_____________________

Name:_______________________________________Relationship:_____________________

Name:_______________________________________Relationship:_____________________

or

- ○ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my dental treatment.

How to Contact

What is your preferred method of communication for us?

First Method of Communication

- ○ Home Phone _________________________
- ○ Work Phone __________________________
- ○ Cell Phone ___________________________
- ○ Email _______________________________

Second Method of Communication

- ○ Home Phone __________________________
- ○ Work Phone ____________________________
- ○ Cell Phone ______________________________
- ○ Email __________________________________

If the above method of Communication is by phone, check the appropriate circle:

- ○ OK to leave a message with detailed information
- ○ Leave a message with call-back number only

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for dental information from persons not listed above will require my specific authorization prior to the disclosure of any dental treatment.

Signature of Patient or Parent (if minor) ____ Date ____________________________________