PATIENT INFORMATION

Date:_____

SS/HIC/Patient ID#:_____

Patient Name:_____

Address:_____

E-Mail:_____

City:_____

State:_____ Zip Code:_____

Sex: ☐ M ☐ F Age_____ Birthday:_____

Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for____years

Patient Employer/School:_____

Occupation:_____

Employers/school phone: (___)_____

Spouse's Name:_____

Birthdate:_____ SS#:_____

Spouse's Employer:_____

Whom may we thank for referring you?_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient_____

Insurance Co._____

Phone # _____Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's name_____

Birthdate_____SS#_____

Relationship to patient_____

Insurance Co._____

Phone # _____Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to

Name of Insurance company(ies)

Dr._____ All insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially risible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or on year from the date signed below.

_____

Signature of patient, Parent, Guardian or personal Representative

Please print name of patient, Parent, Guardian or personal Representative

_____ _____

Date Relationship to Patient

PHONE NUMBERS

Home (___)_____ Work(____)_____ Ext_____Cell Phone(____)_____

Spouse's Work (___)_____ Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name_____ Relationship_____

Home Phone (____)_____ Work Phone(___)_____

DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/state_____

Date of last dental visit_____

Date of last dental X-ray_____

Place a mark on "yes" or "no" to Indicate if you have had any of the Following:

Bad Breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Dry Mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Foreign objects ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken filling ☐ Yes ☐ No

Mouth Breathing ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

sensitivity to cold ☐ Yes ☐ No

sensitivity to heat ☐ Yes ☐ No

sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths ☐ Yes ☐ No

How often do you floss?_____

How often do you brush?_____

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively to as "fen-phen?" These include combinations of Ionimin, Adipe, Fastin (brand names of phentermine), Pondimin (fenfuramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you had any of the following:

ADD/ADHD	☐ Yes ☐ No				
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial heart valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial joints	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back problems	☐ Yes ☐ No	Hepatitis Type____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with Extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High blood pressure	☐ Yes ☐ No	Swollen feet or ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cortisone treatments	☐ Yes ☐ No	Mitral Valve	☐ Yes ☐ No		
Cough, Persistent or bloody	☐ Yes ☐ No	Nervous problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Peacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
		Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Due date_____

Are you nursing? ☐ Yes ☐ No

MEDICATIONS	ALLERGIES	
List any medications you are currently taking and correlating diagnosis:	☐ Aspirin	☐ Local Anesthetic
_____	☐ Barbiturates (Sleeping Pills)	☐ Penicillin
_____	☐ Codeine	☐ Sulfa
Pharmacy Name_____	☐ Iodine	☐ Other_____
Phone (___) _____	☐ Latex	_____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what?_____

Patient's signature_____ Date_____

Doctor's Signature_____Date_____

Has there been any change in your health since last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what?_____

Patient's signature_____Date_____

Doctor's Signature_____ Date: _____

We Smile Dental

We Smile When You Smile

A courtesy of 48 hours notice is required if you are unable to keep your reserved appointment. Please note a $50.00 charge may result if 48 hours notice is not given. Your insurance does not cover this charge.

Please be on time for your appointments. To give you the best quality of care the Doctor has reserved the appropriate amount of time. If you arrive more than 10 minutes late for your scheduled appointment, you may have to reschedule. This is for the benefit of you and other patients being treated.

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also accept CareCredit which is a third party financing company that allows you to start treatment today and spread payments over time. Applying for CareCredit only takes a few minutes and there is no fee to apply.

Please note below are the methods of payment that we accept in our office:

☐ Cash ☐ Check ☐ Major Credit Card

☐ CareCredit (Subject to credit approval.) If credit application is declined, another form of payment listed above is required.

I approve that images of my dental health before, during and after treatment may be used for dental education, marketing, social media, lectures and scientific study. I understand that my name will not be used and images will not be sold for any other use. I also understand that I will not be compensated for the use of my photograph unless otherwise discussed.

I am the patient or parent/guardian and I authorize the examination and treatment as necessary by or under the supervision for the Doctor(s) of We Smile Dental. This includes exposure of radiographs as necessary, use of local anesthetic, and the use of appropriate medicaments and materials for such treatment. By my signature below, I consent to the treatment described in this document. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Treatment not covered by your insurance is your responsibility. Payment of estimated patient portion is expected the day services are rendered. If a debt is sustained with us, your information and account will then be forwarded to a collection agency/or lawyer to handle settlement of your account. If this does occur, you as a patient will be responsible for any and all finance charges, court cost, and collection agency fees and/or attorney fees.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print name of Patient/Guardian Date

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Chicago, IL 60707
(773) 237-8855

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Chicago, IL 60639
(773) 237-2055

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We Smile Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of We Smile Dental's Notice of Privacy Practices.

_____
Patient's Name

_____
Signature

_____
Date

For We Smile Dental 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

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____