DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(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 responsible 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 one 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

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

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 (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

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

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

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

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

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
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex	_____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your 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 your 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 _____

DENTAL INFORMATION RELEASE FORM (HIPAA)

Downtown Dental & Implants of Oswego, Inc.

60 Main St. Suite C Oswego, IL 60543

Dr. Shalini Mohan, D.M.D

Patient Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Can we send you promotional emails? YES or NO

Preferred method of contact/appointment confirmation (please check one):

- ☐ Call home phone
- ☐ Send me a text message
- ☐ Send me an email

If unable to reach me at preferred method, you may:

- ☐ Leave me a detailed message
- ☐ Leave me a message asking to return your phone call, no details may be left.

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me an claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ DO NOT RELEASE MY INFORMATION TO ANYONE.

*THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

Patient Name (print): _____ Date: _____

Patient Signature: _____ Date: _____

Witness Name (print): _____ Date: _____

Witness Signature: _____ Date: _____

Downtown Dental & Implants of Oswego, INC.
FINANCIAL POLICY AGREEMENT

Thank you for choosing Downtown Dental & Implants of Oswego for your dental needs! We are committed to providing you with the highest quality, personal dental care, and appreciate your commitment to adhere to this **Financial Policy Agreement**. We require all of our patients to read, understand, and sign it prior to any non-emergent treatment or care.

Appointments:

We understand circumstances may arise that require you cancel your appointment. Cancellations and appointment changes must be made by calling our office during our normal business hours (8:00 a.m. to 5:00 p.m. Mon, Tues, Thurs, 8:00am-7:00pm Wed, and 8:00am-12:00pm Fri). All cancellations require a 48 hour advanced notice, and cannot be made by voice mail, text or E-mail. This is important. If appointment is failed/cancelled less than 48 hours in advance, you will be charged a $50.00 cancellation fee.

Treatment Plans:

Treatment recommendations are based on the advanced training and experience of the Doctor. A cost estimate will be provided. However, clinical observations during a procedure may alter the treatment plan, causing estimated costs to fluctuate. You are responsible for any change in treatment costs as well as any balance not paid by your insurance.

Insurance and Past Due Balances:

As a courtesy to you we will file claims on your behalf. ALL COPAYS WILL BE COLLECTED AT THE TIME OF SERVICE. In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card at **each** visit.

You are responsible for ensuring your information is correct and effective at the time of each service.

All past due balances are due and payable at time of service.

Insurance Coverage:

- Commercial/Indemnity Insurance: Your policy is a contract between you and your insurance company. Because we are not a party to that contract, your account balance is your responsibility whether your insurance pays or not. Take time to read your insurance policy, and be sure to know what your deductibles are.
- Self Pay or Self Filing: Patients who do not have insurance coverage, who are unable to provide us with valid insurance information or who wish to file their own insurance claims are responsible for paying at the time services are rendered.

Payments:

All co-payments and deductibles designated by your insurance company are your responsibility and are **due at time services are rendered.** Any account balances billed to you must be paid within **30** days.

We do provide in-office payment plans as well as accept Care Credit's INTEREST FREE PLAN. If you are interested, please contact www.CareCredit.com. In the event you disagree with a balance due, it is your responsibility to contact the office's billing department to discuss any discrepancies within **30** days of receiving your statement.

Methods of Payment:

We accept Cash, Checks, American Express, Discover, Visa, and Master Card. A $25 fee will be charged for checks returned for insufficient funds.

Past Due Accounts:

In the event you have an unpaid balance 90 days overdue, appropriate action will be taken to collect the past due amount, and you will be responsible for the following additional fees:

- 40% collection fee added to the unpaid balance if your account is turned over to a collection agency

I hereby authorize my insurance benefits be paid directly to Downtown Dental & Implants of Oswego, INC. I am financially responsible for non-covered services, co-payments, coinsurance, and deductibles. I also authorize Downtown Dental & Implants of Oswego, INC. to release any information required for the processing of this claim and all future claims.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

_____ _____

Print Patient's Name Date

_____ _____

Signature of Patient or Guarantor Date