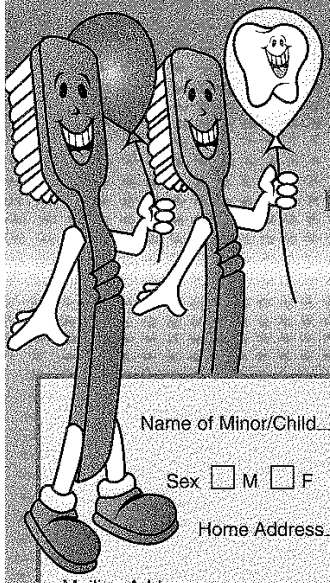
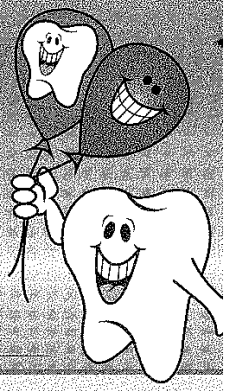


Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION

Date _____

Name of Minor/Child _____ (Last Name) _____ (First Name) _____ (Initial)

Sex ☐ M ☐ F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____

Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____

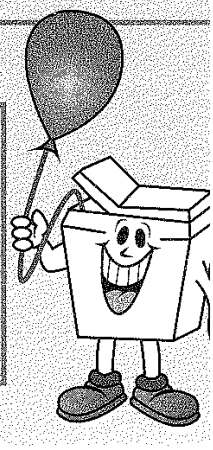
Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐			



Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

Allergies _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✔)

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

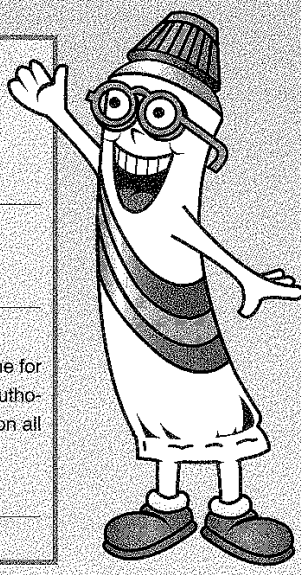
EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATIONS



The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____ _____

Signature of Parent/Guardian Date

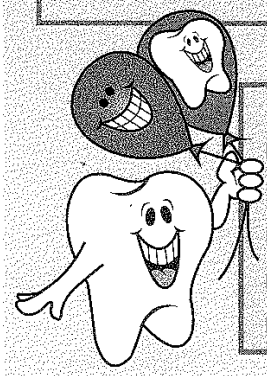
I certify that my minor/child is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to 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 hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian Date



UPDATE

(To be completed at later visit)

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

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