modern essence DENTISTRY
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Office: (630) 582-0878 Fax: (630) 582-0898
www.modernessencedentistry.com

Date: _____

PATIENT INFORMATION

Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Sex: M ___ F ___ Married ___ Widowed ___ Single ___ Minor ___
Separated ___ Divorced ___ Partnered for ___ years
Home Phone #: _____ Cell Phone #: _____ Email: _____
Employer _____ Work #: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Spouse or Parent's Name: _____ Employer: _____ Phone #: _____
Person to contact in case of emergency: _____ Phone #: _____

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name: _____ Birthdate: _____ Relation to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Email: _____ Current Patient: Y ___ N ___
Insurance Company: _____ ID# _____ GRP#: _____
Insurance Address: _____ Insurance Phone #: _____
Subscriber Name: _____ Birthdate: _____ SS #: _____
Employer _____ Work #: _____ Cell #: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

ADDITIONAL INSURANCE

Insurance Company: _____ ID# _____ GRP#: _____
Insurance Address: _____ Insurance Phone #: _____
Subscriber Name: _____ Birthdate: _____ SS #: _____
Employer _____ Work #: _____ Cell #: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?
□Patient, Friend/Family - Name _____ □Other _____
□Dental Office □Yellow Pages □Google □Newspaper □School □Work □Post Card □Money Saver □800-Dentist

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collecting between the teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

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), Pndimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you ever had any serious illnesses or operations?? ☐Yes ☐No If yes, describe _____

Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check (✓) if you have or have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis A, B or C (circle one)
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ None
- ☐ Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain right to privacy regarding my protected health information. I understand that his information can and will be used to:

1) *Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who* may be involved in that treatment directly and indirectly.
2) Obtain payments from third-party payers.
3) Conduct normal health care operation such as quality assessments and physicians certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print):_____ Date of Birth: _____
Patient Signature: _____ Date: _____

Parent/Guardian Name (print): _____ Relationship to patient: _____
Parent/Guardian Signature: _____ Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Written Communications: (Please fill in all that apply)

Home Number: _____
May we leave a message? Yes__ No__

Work Number: _____
May we leave a message? Yes__ No__

Cell phone Number: _____
May we leave a message? Yes__ No__

Email: _____

*Oral Communications:

May we leave a message that you need pre-medication? Yes____ No____
May we leave a message that you have a dental appointment? Yes____ No____
I do not want any reminder messages left at all. (Initials) _____
I do not want a postcard sent. (Initials) _____
(I understand that the office may charge me should I fail to keep my appointment)

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices* but was unable to do so as documented below

Date: _____ Reason: _____ Initials: _____

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CONSENT FOR SERVICES AND PAYMENT OPTIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that they are responsible for their balance regardless of Insurance. This office will obtain the patients insurance benefits before the date of service. Deductibles, co-insurances or services not covered by insurance will be due at the time of service.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I give permission for my dentist and his/her clinical team to take any necessary diagnostic, photos or study models to enable complete diagnosis and treatment. I also give permission for any photos to be used for educational purposes.

Payment Options
You may choose from the following:

- Cash, Check, Visa/MasterCard, America Express, Discover
- Convenient monthly payment plans from CareCredit
  - Allow you to pay over a period of time
  - No annual fees or pre-payment penalties

Please note:
A fee of $25.00 will be charged for patients who miss an appointment more than one time in a calendar year without a 24-hour notice.

A fee of $30.00 will be charged for any returned checks.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date _____
Signature of patient, parent or guardian
Relationship to Patient _____

_____ Date _____
Signature of guarantor of payment/responsible party
Relationship to Patient _____