



# Dental Professionals OF ALGONQUIN

*cosmetic & general dentistry*

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male / Female

Phone # (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Please check the appropriate box:  Child  Single  Married  Divorced  Widowed  Other

Best time to call: \_\_\_\_\_ Which number to call first?:  Home  Work  Cell

Address: \_\_\_\_\_  
Street City State Zip Code

Preferred appointment times:  Morning  Afternoon  Evening  Any Time --  M  T  W  T  F  S

In case of emergency, who should we contact?: \_\_\_\_\_ Phone#: \_\_\_\_\_

Emergency contacts relationship to you? \_\_\_\_\_

## Party Responsible for Payment Information

The following information is for:  self; (info same as above)  the patient's spouse  the patient's guardian/parent  Other \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone # (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

## Primary Dental Insurance Information

Insured (Subscriber's) Name: \_\_\_\_\_ Is subscriber a patient here?  Y  N  
Last First MI

Patient's relationship to Subscriber:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

Subscriber's Birth Date: \_\_\_\_\_ S.S #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Home Address: \_\_\_\_\_  
Street City State Zip Code

Subscriber's Employer/Group Name: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Yellow Pages  Newspaper  School  Work  Community Magazine  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_



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## Patient Medical History

Physician: \_\_\_\_\_ Office Phone#: \_\_\_\_\_ Last Exam Date: \_\_\_\_\_

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Are you under medical treatment?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?<br>If yes, please explain _____ | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 3. Are you taking any medication(s) including non-prescription medicine?<br>If yes, what medication(s) are you taking? _____              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 4. Have you ever taken Fen-Phen/Redux?  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 5. Do you use tobacco?  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 6. Do you use controlled substances?  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 7. Are you allergic to or have you had any reactions to the following:  |                              |                             |
| -Local Anesthetics (e.g. Novocain)  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Penicillin   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Sulfa Drugs  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Barbiturates/other medicines   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Iodine   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Aspirin  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Any Metals (e.g. nickel, etc)  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Latex Rubber   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Other: _____   | <input type="checkbox"/>     | <input type="checkbox"/>    |

8. Do you require antibiotics/pre-med prior to dental work?  YES  NO

9. Have you ever had any of the following? **Please check those that apply:**

- |  |
|--|
| <input type="checkbox"/> High Blood Pressure     |
| <input type="checkbox"/> Low Blood Pressure      |
| <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Swollen Ankles          |
| <input type="checkbox"/> Fainting/ Seizures      |
| <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Heart Attack            |
| <input type="checkbox"/> Epilepsy/Convulsions    |
| <input type="checkbox"/> Leukemia                |
| <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Kidney Disease          |
| <input type="checkbox"/> AIDS or HIV Infection   |
| <input type="checkbox"/> Sexually Trans. Disease |

- |   |
|---|
| <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Cardiac Pacemaker  |
| <input type="checkbox"/> Heart Murmur       |
| <input type="checkbox"/> Angina             |
| <input type="checkbox"/> Frequently Tired   |
| <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Emphysema          |
| <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Joint Replacement  |
| <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Thyroid Problem    |
| <input type="checkbox"/> Heart Trouble      |

- |  |
|--|
| <input type="checkbox"/> Chest Pains               |
| <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Hay Fever/Allergies       |
| <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Radiation Therapy         |
| <input type="checkbox"/> Glaucoma                  |
| <input type="checkbox"/> Recent Weight Loss        |
| <input type="checkbox"/> Liver Disease             |
| <input type="checkbox"/> Sinus Problems            |
| <input type="checkbox"/> Stomach Problems/Ulcer    |
| <input type="checkbox"/> Respiratory Problems      |
| <input type="checkbox"/> Mitral Valve Prolapse     |
| <input type="checkbox"/> FamilyHistory of Diabetes |

- |   |
|---|
| <input type="checkbox"/> Other: _____                 |
| <b>WOMEN ONLY:</b>                                    |
| <input type="checkbox"/> Pregnancy<br>Due Date: _____ |
| <input type="checkbox"/> Nursing                      |
| <input type="checkbox"/> Oral Contraceptives          |
|   |
|   |
|   |
|   |

## Patient Dental History

Name of previous Dentist & Location: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

- |   |                              |                             |   |                              |                             |
|---|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Do your gums bleed while brushing or flossing?                 | YES <input type="checkbox"/> | NO <input type="checkbox"/> | 11. Have you ever had any difficult extractions?  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?         | <input type="checkbox"/>     | <input type="checkbox"/>    | 12. Have you had any orthodontic treatment?   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?       | <input type="checkbox"/>     | <input type="checkbox"/>    | 13. Do you wear dentures or partials?   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 4. Do you feel pain to any of your teeth?                         | <input type="checkbox"/>     | <input type="checkbox"/>    | If yes, date of placement _____   |                              |                             |
| 5. Do you have any sores or lumps in or near your mouth?          | <input type="checkbox"/>     | <input type="checkbox"/>    | 14. Have you ever received oral hygiene instructions regarding the care of your teeth & gums? | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 6. Have you had any head, neck, or jaw injuries?                  | <input type="checkbox"/>     | <input type="checkbox"/>    | 15. Do you like your smile?   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 7. Are you experiencing any of the following problems in you jaw: |                              |                             | 16. How many times a day do you brush? _____  |                              |                             |
| -Clicking   | <input type="checkbox"/>     | <input type="checkbox"/>    | 17. How many times a day do you floss? _____  |                              |                             |
| -Pain (joint, ear, side of face)                                  | <input type="checkbox"/>     | <input type="checkbox"/>    | 18. How much coffee/soda do you drink a day? _____  |                              |                             |
| -Difficulty in opening or closing                                 | <input type="checkbox"/>     | <input type="checkbox"/>    | 19. Do you have any dental problems you would like to discuss with the dentist or hygienist?  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| -Difficulty in chewing  | <input type="checkbox"/>     | <input type="checkbox"/>    |   |                              |                             |
| 8. Do you have frequent headaches?                                | <input type="checkbox"/>     | <input type="checkbox"/>    |   |                              |                             |
| 9. Do you clench or grind your teeth?                             | <input type="checkbox"/>     | <input type="checkbox"/>    |   |                              |                             |
| 10. Do you bite your lips or cheeks frequently?                   | <input type="checkbox"/>     | <input type="checkbox"/>    |   |                              |                             |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis & the records of any treatment or examination rendered to me or child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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## FINANCIAL AGREEMENT

We are committed to providing you, our patient, with exceptional state of the art dental care based on your individual needs. Our goal is to not let expense prevent you from receiving the quality care and service you deserve. To assist in receiving this care, we offer several flexible payment options to fit your needs and help you maintain and enjoy a healthy, attractive smile.

### -DENTAL INSURANCE-

- We will assist you in every way possible to maximize your dental insurance benefits, including retrieving estimated benefits, filling out and filing the claim forms at no charge. Nevertheless, your policy is an agreement between you and your insurance company, not between your insurance company and our office. We can make no guarantee of any estimated coverage, but we'll do our best to see that you receive your maximum benefits.

- **Please keep in mind that you are responsible for your total obligation, should your insurance benefits result in less coverage than you anticipated, regardless of the reason of nonpayment.** Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co payments are due at the time of treatment.

- We are only able to file your primary dental insurance claims. You may file the secondary insurance claim. (We are more than happy to provide you with any additional information you may need to process these claims.)

### -PAYMENT POLICY-

- We accept cash, personal checks, VISA, MasterCard and American Express. (Any returned checks will receive an additional \$25 reprocessing fee, in addition to the bank fee.)

- The parent or guardian accompanying a minor is responsible for full payment. In the case of divorce/separation, the parent/guardian that brought the minor to the appointment is responsible for payment.

- Copies of any professional records, such as x-rays, will be charged a \$20 duplication fee.

- **Payment is due at the time services are rendered. In the case of dental insurance, your *estimated* patient portion would be due at the time of service. Once your insurance has paid their portion, any remaining balance would become your full responsibility. Please note there will be a finance charge of 2% per month (of the full balance) applied on any remaining balance after 60 days.**

- Extended payment plans are available upon credit approval. Otherwise, payment is expected at the time services are performed. When extensive dental care is necessary, arrangements may be made with our financial coordinator. Please have these options reviewed prior to beginning treatment.

Our purpose is to maximize your insurance benefits and make any treatment easily affordable. If you have any questions regarding your treatment or insurance benefits, please do not hesitate to contact our office.

Responsible party signature \_\_\_\_\_ Date \_\_\_\_\_



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OSHA / HIPAA

To ensure the safety of our staff and provide privacy to all of our patients (in compliance with OSHA Standards, and the Federal Governments HIPAA Privacy Policy Act), **we request that ONLY patients receiving treatment enter the patient operatories and surrounding areas.**

In the instance of small children, parents may accompany their child to the treatment area to see that they are settled before returning to the waiting room.

We thank you for your cooperation.

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I have read the above office policy, and agree to abide by the set HIPAA Privacy/OSHA standards for my personal privacy, and the privacy of others.

-----  
Signature

-----  
Date



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I, \_\_\_\_\_, have been given the opportunity to review/receive a copy of this office's Notice of Privacy Practices.

\*You may refuse to sign this Acknowledgement\*

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dental Professionals of Algonquin.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Dental Professionals of Algonquin. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**I have had full opportunity to read the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

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(Please print name)

(Date)

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(Signature)



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## Dental Disclosure Form

\*OPTIONAL FORM THAT MAY BE COMPLETED BY THE PATIENT IF HE/SHE IS OVER 18 YEARS OLD.\*

Please note, if this form is not completed, our office is prohibited from releasing any information regarding the patient (over 18 years old) to **any** individual, other than the patient.

I, \_\_\_\_\_ give Dental Professionals of Algonquin permission to discuss and release any dental records and/or information regarding treatment, payment, and health operations to the following individuals:

- \_\_\_\_\_  
(Name) \_\_\_\_\_  
(Individual's relationship to patient)
- \_\_\_\_\_  
(Name) \_\_\_\_\_  
(Individual's relationship to patient)
- \_\_\_\_\_  
(Name) \_\_\_\_\_  
(Individual's relationship to patient)
- \_\_\_\_\_  
(Name) \_\_\_\_\_  
(Individual's relationship to patient)
- \_\_\_\_\_  
(Name) \_\_\_\_\_  
(Individual's relationship to patient)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date