Instructions

Please fill out the form as completely as possible. When you're done, you have two choices. Click the button below to either:

1) Click the "Submit by Email" button and send this document to our office; or
2) Print the form and bring it with you to your appointment

Smiling Patient Dental Care
Bianca Malin,DDS Patrick Magner,DMD
322 N. Wolf Rd Mt. Prospect, IL 60056
847.824.5151 office 847.824.8981 fax
www.smilingpatient.com

Welcome

Print Form

Reset Form

Patient Information

SSN ____________ Current Date ____________

First Name ____________ Initial ____ Last Name ____________

Address ____________________________

City ____________ State ____ Zip Code ____________

Sex ______ Marital Status ______ Birthday ____________

Occupation ____________________________

Employer ____________________________

Contact Information

Email ____________________

Home Phone ____________

Work Phone ____________

Cell Phone ____________

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

Name ____________________

Home Phone ____________________

Relationship ____________________

Questionnaire

Whom may we thank for referring you? ____________

What is important to you when choosing your new dentist? ____________

Question		
Are you satisfied with your tooth appearance?	◯ Yes	◯ No
Are you satisfied with your tooth color?	◯ Yes	◯ No
Do you feel your teeth are crowded?	◯ Yes	◯ No
Do you feel your teeth are poorly aligned?	◯ Yes	◯ No
Do you feel your teeth are protruding?	◯ Yes	◯ No
Do you suffer from dental decay in your front teeth?	◯ Yes	◯ No
Do you have non-esthetic front teeth restorations?	◯ Yes	◯ No
Do you have fractures in your front teeth?	◯ Yes	◯ No
Are you hiding your teeth while smiling?	◯ Yes	◯ No

Dental Insurance

Relationship to Patient? ____________________

Insurance Company ____________________

Subscriber's Name ____________________

Subscriber's Birthday ____________ SSN ____________

Group # ____________________

Medications

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

☐ None

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Skin reaction to jewelry
☐ Any known metal allergies
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other (Specify)
☐ None

Dental History

Reason for Today's Visit

Former Dentist

City/State

Date/Last Visit

Date/Last Dental X-Rays

Please select "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
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
Smoking or Tobacco use	◯ Yes	◯ No
Clicking or popping jaw	◯ Yes	◯ No
Dry mouth	◯ Yes	◯ No
Fingernail biting	◯ Yes	◯ No
Food collection between teeth	◯ Yes	◯ No
Grinding Teeth	◯ Yes	◯ No
Loose teeth or broken fillings	◯ 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 in your mouth	◯ Yes	◯ No

How often do you brush?

How often do you floss?

Health History

Physician's Name

City/State

Date/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), Pondimin (fenfluramine), and Redux (dexfenfluramine?) ◯ Yes ◯ No

Please select "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	◯ Yes	◯ No
Anemia	◯ Yes	◯ No
Arthritis, Rheumatism	◯ Yes	◯ No
Artificial Heart Valves	◯ Yes	◯ No
Artificial Joints	◯ Yes	◯ No
Asthma	◯ Yes	◯ No
Back Problems	◯ Yes	◯ No
Bleeding abnormally, with extractions or surgery	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Cancer	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Circulatory Problems	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No
Cortisone Treatments	◯ Yes	◯ No
Cough, persistent or bloody	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Do you wear contact lenses?	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No
Fainting or dizziness	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No
Headaches	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Heart Problems	◯ Yes	◯ No
Hepatitis Type ___	◯ Yes	◯ No
Herpes	◯ Yes	◯ No
High blood pressure	◯ Yes	◯ No
Jaundice	◯ Yes	◯ No
Jaw Pain	◯ Yes	◯ No
Kidney Disease	◯ Yes	◯ No
Liver Disease	◯ Yes	◯ No
Low Blood Pressure	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Nervous Problems	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Psychiatric Care	◯ Yes	◯ No
Radiation Treatment	◯ Yes	◯ No
Respiratory Disease	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No
Scarlet Fever	◯ Yes	◯ No
Shortness of breath	◯ Yes	◯ No
Sinus trouble	◯ Yes	◯ No
Skin rash	◯ Yes	◯ No
Special diet	◯ Yes	◯ No
Stroke	◯ Yes	◯ No
Swollen feet or ankles	◯ Yes	◯ No
Swollen neck glands	◯ Yes	◯ No
Thyroid problems	◯ Yes	◯ No
Tonsillitis	◯ Yes	◯ No
Tuberculosis	◯ Yes	◯ No
Tumor or growth on head or neck	◯ Yes	◯ No
Ulcer	◯ Yes	◯ No
Weight loss, unexplained	◯ Yes	◯ No

Please identify special needs or anything you feel will help

Women Only:

Question	Yes	No
Are you pregnant?	◯ Yes	◯ No
Are you nursing?	◯ Yes	◯ No
Taking birth control pills?	◯ Yes	◯ No

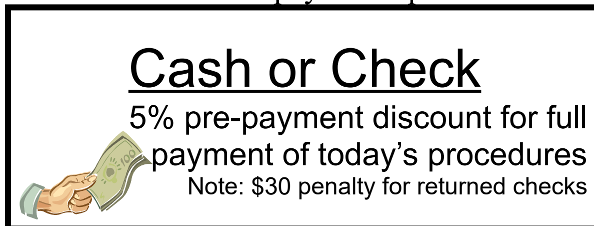
Due date

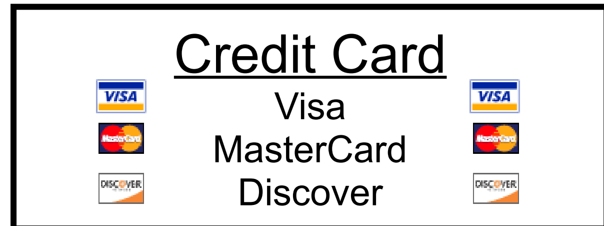
SMILING PATIENT DENTAL CARE
THE SMILE STUDIO

FINANCIAL AGREEMENT

We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients' financial capabilities.

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several convenient payment options:





Half up front,
Half before completion
For your convenience
$500 minimum purchase

0% CareCredit Financing
For qualified applicants
$500 minimum purchase

Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly, therefore, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.

Please be aware that we will always review your proposed treatment and answer any questions related to your personal financial responsibility and insurance benefits. **We must emphasize that as dental care providers, our relationship is with you, not with your insurance company.** Please be aware that:

- Your insurance contract is between you, your employer, and the insurance company. **We are not a party to that contract.**
- Our fees are considered to fall within the acceptable range by most companies and therefore, are covered to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (Such as 50% or 80%) of the "U.R.C." defined as usual, reasonable, and customary fees for this region. However, we cannot guarantee that our fees will always fall within this range.
- **Not all services are a covered benefit in all contracts.** Some employers and insurance companies arbitrarily select particular services that are not covered by their benefit plan.

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We encourage you to read your insurance policy so you are fully aware of the benefits and any limitations that were negotiated by your employer with your insurance company.

Please acknowledge your understanding of the following by signing below:

- **Payment is due at the time services are rendered.**
- As a courtesy service to you, **we will submit your insurance claim for your direct reimbursement** using the fastest means available.
- **Cash, Check, Visa, MasterCard, and Discover Card** are always welcome.
- For your convenience, we offer financing and/or payment plan options through Capitol One and CareCredit, which provides an **array of financing options, including interest-free payments for comprehensive treatment plans**. Inquire for details.
- **Returned checks are subject to a $30 returned check fee.**
- **Cancellations require 24 hour notice. Appointments canceled within 24 hours will be charged a $50 missed appointment fee.**
- **No show appointments will be charged a $50 missed appointment fee.**
- Outstanding balances **older than 60 days are subject to an interest charge of 1.5% per month.**
- **Outstanding balances older than 120 days may be relinquished to a collection agency.**

Please feel free to contact us with any questions. We are here to help you.

Thank you for your commitment to our practice. We look forward to seeing your smile and working together to provide a caring and comfortable environment for your optimal oral health care.

Print Name: ________________________

Signature: ___________________________ **Date:** _____________

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Print Form

SMILING PATIENT DENTAL CARE
THE SMILE STUDIO

Notice of Privacy Practices Acknowledgement

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

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in treatment directly and indirectly.
- Obtain Payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 questions. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name ____________________

Relationship to Patient ____________________

Signature: ____________________

Date ____________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so even though the Notice of Privacy Practices was received as documented below:

Date ____________ Initials ______ Reason ____________________

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