

Medical History

When was your last physical exam? _____ Last blood test? _____

Have you been under a care of a medical doctor in the past two years? Yes or No

If yes, for what condition? _____

Physician's name: _____ Phone # _____

Have you taken any prescription medications during the past two years? Yes or No

If yes, please list the medications:

Prescription medications now taking: Please give name, dosage and for what condition:

Are you allergic to any medications or substances that cause adverse reactions to you? Yes or No

If yes, please list medications:

Have you been hospitalized or had an operation within the past five years? Yes or No

If yes, what was it for?

Do you have or ever had any of the following?

- | | | | | | |
|-------------------------------------------------|-----|----|--------------------------------|-----|----|
| Heart (surgery, disease, attack, stroke) | yes | no | Asthma | yes | no |
| Chest pains | yes | no | Hay fever | yes | no |
| Congenital heart disease..... | yes | no | Latex sensitivity | yes | no |
| Heart murmur | yes | no | Allergies or hives | yes | no |
| High or Low blood pressure | yes | no | Sinus trouble | yes | no |
| Mitral valve prolapse | yes | no | Radiation therapy | yes | no |
| Artificial heart valves | yes | no | Chemotherapy | yes | no |
| Heart pacemaker | yes | no | Tumors | yes | no |
| Rheumatic fever | yes | no | Hepatitis A or B | yes | no |
| Arthritis or/and rheumatism | yes | no | Tuberculosis | yes | no |
| Steroid usage (internally and/or externally) .. | yes | no | A.I.D.S. | yes | no |
| Swollen ankles | yes | no | H.I.V. positive | yes | no |
| Artificial joints (hips, knees, etc.) | yes | no | Blood transfusions | yes | no |
| Kidney trouble | yes | no | Hemophilia | yes | no |
| Ulcers (internally and externally) | yes | no | Sickle cell disease | yes | no |
| Diabetes | yes | no | Liver disease | yes | no |
| Thyroid problems (hyper or hypo) | yes | no | Yellow jaundice | yes | no |
| Glaucoma | yes | no | Neurological Disorders.... | yes | no |
| Contact lenses | yes | no | Epilepsy or seizures | yes | no |
| Emphysema | yes | no | Fainting or dizzy spells | yes | no |
| Lasik Surgery | yes | no | Cancer | yes | no |
| Chronic cough | yes | no | Nervous/anxiety attacks | yes | no |
| Psychiatric/psychological care | yes | no | | | |

Have you lost or gained 10 pounds or more in the past year? Yes or No

Are you experiencing excessive stress or pressure at your work or at home? Yes or No

Do you have or have you had any disease, condition, or problem not listed above? Yes or No

If yes, please list:

For Women: Are you pregnant? Yes or No

Are you nursing? Yes or No

If yes, how many months? _____ Are you taking birth control? Yes or No

DENTAL HISTORY

So that we may provide you with the best possible care, please fully complete both sides of this form. All information will be kept completely confidential.

Name _____ Date _____

What is the reason for your visit today? _____

Date of last dental visit _____ Last dental cleaning _____

What was done at the last dental visit?

How often do you have dental examinations?

How often do you brush daily? 1x 2x 3x 4x

How often do you floss: 1x/day 2x/day 3x/day 1x/week 1x/month

What other dental aids do you use? Night Guard Toothpicks Electric Toothbrush Floss Mouth Washes

Do you have any discomfort at this time? Yes No

If yes, please describe:

Have you had an upsetting dental experience? Yes No

If yes, please describe:

Does dental treatment make you nervous? Yes No slightly moderately extremely

Are you satisfied with the appearance of your teeth? Yes No

If no, how would you like to improve the appearance of your teeth?

Do you have any of the following?

Mouth Teeth

- | | | | | | |
|----------------------------------------|-----|----|-------------------------------|-----|----|
| Bleeding and/or sore gums | yes | no | Loose teeth | yes | no |
| Unpleasant taste and/or bad breath .. | yes | no | Sensitive to hot | yes | no |
| Frequent cold sores or blisters | yes | no | Sensitive to sweets | yes | no |
| Swelling or lumps | yes | no | Sensitive to biting | yes | no |
| Orthodontic treatment | yes | no | Food impaction | yes | no |
| Biting cheeks or lips | yes | no | Clenching or grinding | yes | no |
| Clicking or popping jaw | yes | no | Change or shifting bite | yes | no |
| Difficulty opening or closing jaw | yes | no | Smoke or chew tobacco... .. | yes | no |

Is there anything else about having dental treatment you would like us to know? Yes no

If yes, please describe:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission of the respective health care provider or agency to release such information to your office. As a patient of Chicago Smiles, I will notify the staff of any changes in my health or the medications I am taking.

Patient or Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

CHICAGO | S M I L E S

In order to provide you with the best treatment and keep the cost of that treatment reasonable, we ask that you review our financial policy. We require that you read and initial the following statement.

_____ Your portions for services rendered are due at the time of service. Patients with insurance are required to pay the deductible (if applicable) and estimated co-payment at the time of service. We are more than happy to assist you with the filing of your insurance, however, keep in mind that the co-pay amount is an ESTIMATE. You are responsible for any account balance that is not paid by your insurance company.

_____ Our policy is that we require your insurance to pay on claims in 60 days. Most insurance companies pay in 45 days. I authorize payment of the dental benefits, otherwise payable to me, directly to Chicago Smiles. If your claim becomes outstanding by 60 days you will be notified on your next statement and the full balance will be due by you. We will no longer bill secondary insurance claims.

_____ If your treatment requires two or more visits to our office (i.e. crowns, bridges, partials or dentures), your payment will be due on the first day of treatment or the "prep date" unless payment arrangements have been made prior to the start of treatment.

_____ We accept payment in the forms of Cash, Check, Visa, MasterCard, Discover or AMEX. Please understand your financial commitment to our office prior to starting any dental treatment. You are responsible for any unpaid balance to the office and any legal fees to collect such debt.

_____ We request that in the need to cancel an appointment, you give us at least 48 hours notice. If 48 hours notice is not given, a fee of \$50.00 per hour of time with a Dental Hygienist and \$75.00 per hour with the doctor reserved may be considered and charged to your account. A deposit may be required to hold an appointment with the hygienist or the dentist.

_____ A finance charge at a periodic rate of 2.25% per month will be imposed on charges not paid in full within 90 days. If your payment is not received by the due date, you may be assessed a late payment charge of \$5.00 or 5% of the past due amount, whichever is greater. The fee for returned checks is \$30.00

_____ In the event of a divorce/separation, the parent/guardian that escorts their child to the dental office will be financially responsible for payment regardless of agreement between parents or the courts,

_____ Our office utilizes mercury-free fillings (white fillings). Please be aware that some insurance will down grade the price of composite (white) fillings to the silver (mercury or amalgam) filling price. You will be responsible for the difference.

_____ Original x-rays are the property of Chicago Smiles. If copies are needed, there is a 10 business day turn around on x-ray copies and a charge of \$45.00 may be assessed.

I have read, understand and agree to the above policy. I understand that I am fully responsible for the fees of service rendered, regardless of any insurance that I may have.

Patient/Responsible Party Signature

_____/_____/_____
Date