Thank you for selecting Total Dental for your dental care needs. We'd love to hear why you chose our practice. Your feedback helps us improve our advertising and allows us to express our gratitude to those who refer us.

PLEASE CHECK HOW YOU INITIALLY HEARD ABOUT OUR OFFICE:

HAVE YOU SEEN OUR COMMERCIAL ON TV? Yes ☐ NO ☐

MEDIA:

☐ WEEK-TV ☐ WHOI-TV ☐ Cable- TV ☐ Radio
☐ Yellow Pages ☐ Newspaper ☐ Internet ☐ Pandora
☐ WCIC Radio ☐ Church Bulletin ☐ Streaming TV ☐ Hulu
☐ Videos on Facebook

WORD OF MOUTH:

☐ Insurance ☐ Doctor ☐ Friend

Sign _____ Total Dental Care Staff Member – Name: _____

Whom may we thank for your referral (if applicable)?

Name _____

Phone _____

Company _____

Email _____

PATIENT INFORMATION

Name of Minor Child (Last, First, Middle) _____

Preferred to be called/Nickname _____ Sex at birth: MALE FEMALE

School and Grade _____ Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Patient's E-mail _____ Home Phone _____

FAMILY INFORMATION

Father's Name _____ Mother's Name _____

Father's Date of Birth _____ Mother's Date of Birth _____

Home Address (if different than patient) Home Address: (if different than patient)

_____ _____

_____ _____

Father's Employer _____ Mother's Employer _____

Father's Work Phone _____ Mother's Work Phone _____

Email Address: _____ Email Address: _____

Other family members treated here: _____

RESPONSIBLE PARTY /INSURANCE INFORMATION

Insured's Name_____ Relationship_____

Insurance Claim's Address_____

City _____ State _____ Zip Code _____

Insured's Social Security Number _____ Insured's Date of Birth _____

Phone _____ Insured's Employer _____ Occupation _____

Business Phone _____

Responsible Party's Social Security Number _____ Relationship _____

To the best of my knowledge, the foregoing questions have been accurately answered.

Signature of Parent or Guardian_____ Date_____

Dental/Allergy History

Patient's Name_____ Date of Birth_____

Date of patient's last dental visit? _____

When was the last time your child had complete dental x-rays taken? _____

Name of previous dentist? _____

Child's Physician _____ Phone Number _____ Date of Last Visit: _____

Emergency Contact _____ Phone Number _____ Relationship: _____

DOES YOUR CHILD HAVE ANY OF THESE ALLERGIES:

- ☐ **Aspirin**
- ☐ **Codeine**
- ☐ **Dental Anesthetics**
- ☐ **Erythromycin**
- ☐ **Latex or Rubber Products**
- ☐ **Metal of Any Kind**
- ☐ **Penicillin**
- ☐ **Tetracycline**

Additional allergies not listed above _____

HAS YOUR CHILD HAD ANY OF THESE DENTAL-RELATED PROBLEMS:

- ☐ **Tongue Thrust**
- ☐ **Lip Sucking/Biting**
- ☐ **Speech Problems**
- ☐ **Clenching/Grinding Teeth**
- ☐ **Mouth Breather**
- ☐ **Nail Biting**
- ☐ **Thumb/Finger Sucking**

- ☐ Child has had injuries to the face, mouth, or chin
- ☐ Child has had pain/tenderness in his/her jaw joint
- ☐ Child brushes teeth daily
- ☐ Child flosses teeth daily
- ☐ Child plays musical instruments that involve the mouth
- ☐ Child has handicaps/disabilities

Health History

- ☐ **Abnormal Bleeding**
- ☐ **Anemia/Radiation Treatment**
- ☐ **Asthma**
- ☐ **Congenital Heart Defects**
- ☐ **Hearing Impairment**
- ☐ **Hemophilia**
- ☐ **Congenital Heart Lesions**
- ☐ **High/Low Blood Pressure**
- ☐ **Mitral Valve Prolapse**
- ☐ **Rheumatic/Scarlet Fever**
- ☐ **Tuberculosis (TB)**
- ☐ **Drug/Alcohol Abuse**
- ☐ **ADD/ADHD**
- ☐ **Artificial Bones/Joints/Valves**
- ☐ **Cancer/Leukemia**
- ☐ **Diabetes**
- ☐ **Heart Attack/Problems**
- ☐ **Hay Fever**
- ☐ **Heart Attack/Disease**
- ☐ **Kidney/Liver Problems**
- ☐ **Mononucleosis**
- ☐ **Sinus Problems**
- ☐ **Arthritis**
- ☐ **HIV Positive (AIDS)**
- ☐ **Cerebral Palsy**
- ☐ **Fever Blisters**
- ☐ **Heart Disease**
- ☐ **Blood Transfusion**
- ☐ **Hepatitis A B C**
- ☐ **Measles/Mumps**
- ☐ **Psychiatric Problems**
- ☐ **Thyroid Disease**

Does the child have any other disease/condition/ problem not listed above the doctor should know about?

☐ Yes ☐ No If yes, what? _____

Please list any current medications being used by your child and the reason for each: _____

_____

_____

FOR ALL PATIENTS:

I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible for my child. I have had the opportunity to discuss my child's Health History with my doctor. I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all the services rendered by this office.

_____

Parent or Guardian Signature Relationship Date

Authorization to Discuss Protected Health Information (PHI)

Please list any individuals you authorize us to discuss your personal information with, aside from yourself. Our staff cannot share your personal information with anyone not listed here, except for your insurance providers and other healthcare professionals.

I, _____, authorize the staff of TOTAL DENTAL CARE, LTD. to discuss my child's PHI with the following individuals:

_____

_____

_____

_____

The Notice of Privacy Practices

☐ Yes, I wish to receive a copy of *The Notices of Privacy Practices*

☐ No, I do not wish to receive a copy of *The Notices of Privacy Practices*

_____ Parent or Guardian's Name (Printed)

_____ _____

Parent or Guardian's Signature Date

FINANCIAL RESPONSIBILITY ASSIGNMENT AND RELEASE

To the extent not paid by the patient's insurer or other party payor(s) within 30 days from the date of first billing, the undersigned agrees, whether he or she signs as agent or patient, that in consideration of the good to be provided and the services to be rendered to the patient, he or she individually obligates himself or herself to pay upon demand, unless other arrangements are approved in writing by Total Dental Care, Ltd. ("Dentist"), the full outstanding balance for the Dentist's actual charges for goods and services provided to the patient at the rates or for such fee(s) as are customary for Dentist. The Patient and/or the undersigned agrees that in the event an employee of Dentist, on his or her own initiative or at the request of the Patient and/or undersigned undertakes to determine the availability of insurance coverage directly or on behalf of the Patient or the undersigned, it shall not be a defense to Patient's and/or the undersigned's financial obligation hereunder that an employee of Dentist re-communicated to Patient and/or the undersigned information received from the Patient's medical insurance carrier to the effect that a procedure or course of treatment was or will be covered under the Patient's policy, notwithstanding that the insurance carrier subsequently denies partial or full payment for such procedure or course of treatment. It is hereby expressly understood and acknowledged by Patient and/or the undersigned that Patient and/or the undersigned are primarily responsible for determining and confirming insurance coverage prior to seeking services.

Beginning on the 30th day from the date service was rendered; all delinquent accounts shall bear interest at the legal rate of eighteen percent (18%) per annum. Should the Account be referred to an attorney or collection agency for collection, the undersigned shall pay all costs of collection, including reasonable attorney fees, collection expenses, costs and court costs which are incurred by the Dentist in enforcing payment after default. There will be a $30.00 charge on all returned checks. It is further hereby agreed that this agreement constitutes the entire agreement of the parties and supersedes and nullifies any prior negotiations, agreements, stipulations or representations unless formalized in writing and directly referencing this agreement. No agent or representative of either party has authority to make, nor is either party relying upon any representation not expressly contained in this Agreement. This Agreement may be amended **only** by an agreement in writing signed by authorized representatives of both parties. It is also agreed that once a suit is filed as a consequence of the undersigned's default with respect to any term or condition of this Agreement, only the Dentist's designated attorney shall have authority to negotiate, compromise or settle any claim arising from such default and that the acceptance of payment by Dentist shall not constitute a waiver of full payment for the amount prayed for by such lawsuit. The undersigned, whether he or she signs as agent or as patient, further authorizes and irrevocably assigns direct payment to Dentist, any insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. The undersigned understands that he or she is responsible for the entire balance on the account notwithstanding the insurance payments which may have been received for services provided. The undersigned hereby consents for a period not exceeding one year to allow Dentist to release patient's financial and medical record and/or copies of pertinent medical record information to Dentist's affiliates and insurance companies or other third-party payors. Of course, the above-stated release may be revoked at anytime by Patient, in writing.

NOTICE TO THE UNDERSIGNED: Do not sign this Assignment and Release before you read it and understand it.

_____ _____

SIGNATURE DATE

_____

PRINT NAME

TO THE PARENTS OR LEGAL GUARDIANS OF MINOR CHILDREN: AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

Illinois law generally provides that only the parent or guardian of a minor child under the age of 18 may consent to dental treatment for that minor. Unless provided for in the Consent by Minors to Medical Procedures Act, it is the policy of TOTAL DENTAL CARE, LTD., not to treat minor children unless they are accompanied by a parent or guardian.

If, at any time in the future, you think you will be sending your minor child to TOTAL DENTAL CARE, LTD., for dental work without being accompanied by a parent or guardian, we need the following authorization to treat the minor child.

I, _____, of _____, County, State of Illinois, am the Parent or Guardian of _____, a minor child, age _____, born on _____, I hereby authorize my child's dentist or any dentist of TOTAL DENTAL CARE, LTD., to treat said minor child even though I will not be present during the minor child's visit with the provider. Furthermore, I authorize the above-mentioned provider to perform any acts that may be necessary or proper to provide for the dental care of the minor child, including but not limited to the power to authorize any dental care, x-rays, examination, treatment and/or injections or nitrous oxide.

This consent shall be effective from the date it is executed until the day I terminate it, in writing. By signing here, I indicate that (1) I have the understanding and capacity to recognize the importance of, to communicate and to assign the dental care decisions covered by this document, (2) I am fully informed as to the contents of this document, and (3) I understand the full scope and importance of this grant of powers to the agent named herein.

_____

Parent or Guardian's Signature Relationship Date