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 Questionnaire

PATIENT INFORMATION

Patient Name _____ _____ _____

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

Social Security Number _____ Date of Birth _____ Age _____

Driver's License/State ID No. _____ Issuing State _____

Home Address _____

City _____ State ____ Zip Code _____

E-mail _____ ☐ Yes, send emails for appointment verifications and special offers ☐ No, thanks

Home Phone _____ Work Phone _____ Cell Phone _____

It is OK to contact me by ☐ Home Phone ☐ Work Phone ☐ Cell ☐ Mail ☐ Email

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status ☐ Full Time ☐ Part Time ☐ FT Student ☐ PT Student ☐ Retired

EMERGENCY CONTACT _____ **Phone number**_____

EMPLOYMENT/INSURANCE INFORMATION

Employer _____ INSURED NAME IN FULL _____

Group Number _____ INSURANCE COMPANY _____

SECONDARY INSURANCE INFORMATION

Employer _____ INSURED NAME IN FULL _____

Group Number _____ INSURANCE COMPANY _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN PATIENT INFORMATION)

Name_____ Relationship _____

Home Address_____

City _____ State ____ Zip Code _____

Social Security Number _____ Date of Birth _____ Phone _____

Employer_____ Occupation_____ Business Phone _____

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

Patient Signature (or Responsible Party, if minor)_____ Date_____ Doctor's Initials _____

Health History

Patient's Name _____Date of Birth _____

When was your last dental visit? _____

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

Name of previous dentist? _____

How much have you neglected your dental treatment because of fear? _____

How do you feel about getting and maintaining a healthy mouth? _____

How do you feel about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

Name of Family Physician_____Specialist_____ Pharmacy _____

PLEASE CHECK THE BOX IF YOU HAVE OR HAVE YOU EVER HAD:

- ☐ **Allergies or Hives**
- ☐ **Anemia**
- ☐ **Angina Pectoris (Chest pain)**
- ☐ **Arthritis**
- ☐ **Artificial Heart Valve**
- ☐ **Artificial Joint**
- ☐ **Asthma**
- ☐ **Blood Transfusion**
- ☐ **Bruise Easily**
- ☐ **Chemotherapy (Cancer, etc.)**
- ☐ **Chronic Cough**
- ☐ **Cold Sores and Fever Blisters**
- ☐ **Congenital Heart Lesions**
- ☐ **Cortisone Medication**
- ☐ **Cosmetic Surgery**
- ☐ **Diabetes**
- ☐ **Drug Addiction**
- ☐ **Emphysema**
- ☐ **Epilepsy/Seizures**
- ☐ **Fainting/Dizzy Spells**
- ☐ **Genital Herpes**
- ☐ **Glaucoma**
- ☐ **Hay Fever**
- ☐ **Heart Disease or Attack**
- ☐ **Heart Failure**
- ☐ **Heart Murmur**
- ☐ **Heart Pacemaker**
- ☐ **Heart Surgery**
- ☐ **Hemophilia**
- ☐ **Hepatitis A (infectious)**
- ☐ **Hepatitis B (serum)**
- ☐ **High Blood Pressure**
- ☐ **HIV Positive (AIDS)**
- ☐ **Joint Replacement**
- ☐ **Kidney Trouble**
- ☐ **Liver Disease**
- ☐ **Mitral Valve Prolapse**
- ☐ **Nervousness**
- ☐ **Pain In Jaw Joints**
- ☐ **Psychiatric Treatment**
- ☐ **Rheumatic Fever**
- ☐ **Rheumatism**
- ☐ **Scarlet Fever**
- ☐ **Shortness Of Breath**
- ☐ **Sickle Cell Disease**
- ☐ **Sinus Trouble**
- ☐ **Stroke**
- ☐ **Taken Phen-Fen or Similar**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis (TB)**
- ☐ **Ulcers**
- ☐ **Venereal Disease (syphilis, etc.)**
- ☐ **Take Blood Thinner Medications**
- ☐ **Yellow Jaundice**

Please list all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins, or minerals: _____

_____

Health History, Page 2

Do you have any other disease, condition, or problem not listed above the doctor should know about? ☐ Yes ☐ No

If yes, what_____

PLEASE CHECK THE BOX IF YOU ALLERGIC OR HAVE YOU HAD AN ADVERSE REACTION TO:

☐ **Local Anesthesia (Novocain, etc.)** ☐ **Penicillin** ☐ **Aspirin or Ibuprofen**

☐ **Codeine or other painkillers** ☐ **Other Antibiotics** _____ ☐ **Metal of any kind**

Latex or Rubber products Any allergies not listed above _____

Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No

If yes, for what reason? _____

Do you use or have you ever used recreational drugs? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No If so, how often_____

Is there any history of alcohol/chemical dependency or emotional disorder that may affect your care? ☐ Yes ☐ No

When you walk upstairs or take a walk, do you ever have to stop because of chest pain, shortness of breath, or exhaustion? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Have you lost/gained more than 10 lbs. in the last year? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Do you ever wake up from sleep short of breath? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

Have you had any serious problems associated with any previous dental treatment? ☐ Yes ☐ No

WOMEN – Are you pregnant or nursing or is there ***any chance*** you might be pregnant? ☐ Yes ☐ No

If you are using oral contraceptives, it is important you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

FOR ALL PATIENTS: ***I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. I have had the opportunity to discuss my 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.***

Patient Signature (or Responsible Party, if minor) Relationship Date Doctor's Initials

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

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 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*

_____

Patient Signature

_____ _____

Patient Signature (or Responsible Party, if minor) Date

SEDATION

FOR PATIENTS INTERESTED IN SEDATION:

Total Dental Care, Ltd. offers patients the alternative of Sedation Dentistry, for patients with dental anxiety, time constraints, or just wanting to rest through their procedures. So that we may better understand you, please check all the items below that would apply:

- ☐ I have had a bad experience(s) at the dentist in the past
- ☐ I have pain when dental work is done
- ☐ I hate the needle and/or shots
- ☐ I cannot get numb even when I do get a local anesthetic
- ☐ I cannot stand to have dental tools in my mouth
- ☐ I hate the sound of the drill
- ☐ I do not like the smell
- ☐ I gag when dental tools are in my mouth
- ☐ In the past, I have avoided going to the dentist and only went when I could no longer stand the pain
- ☐ I have canceled dental appointments or just not shown up due to fear/anxiety
- ☐ Time is an issue – it is difficult for me to return for multiple appointments

Please write down anything we have not included that would explain why you are interested in sedation dentistry:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature (or Responsible Party, if minor) Relationship

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