

NORTHBROOK DENTAL CARE, LTD.

Timothy D. Tishler, D.D.S.

1135 Church St., Northbrook, IL 60062 (847)205-9337

www.northbrookdentalcare.com

Welcome! Thank you for selecting our dental healthcare team.

We will strive to provide you with the best possible dental care. To help us meet all your dental care needs, please fill out this form completely. If you have any questions, or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION

Date: _____

Name: Mr. Mrs. Dr. Ms. First: _____ Last: _____

Social Security #: _____ Birth Date: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Name: _____ Email Address: _____

Cell Phone: _____ Best way to reach you during the day? _____

Check Appropriate Category: Minor Single Married Student

If Student, FT PT Name of School/College _____ City _____ State: _____

If Minor, Parent or Guardian Name: First: _____ Last: _____

Patient's or Parents' Employer: _____ Business Phone: _____

Business Address: _____

How did you hear about us? _____

What is the best time for your appointments? Days: _____ Times: _____

Person to contact in case of emergency: _____ Phone: _____

RESPONSIBLE PARTY

Name of Person Responsible for This Account: _____

Relationship to Patient: _____ Home Phone: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Is This Person Currently a Patient in Our Office? Yes No

DENTAL BENEFIT INFORMATION

Name of Insured: _____ Social Security #: _____

Birth Date: _____ Relationship to Patient: _____

Name of Employer: _____ Work Phone: _____

Insurance Company Name: _____ Group #: _____

Insurance Company Phone #: _____ Have you used any of your benefits this year? Y N

If yes, how much? _____

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: _____ Date of last Exam: _____

1. Do you have or have you had any of the following:

High blood pressure	Yes	No	Heart Disease	Yes	No	Chest Pains	Yes	No
Heart Attack	Yes	No	Cardiac Pacemaker	Yes	No	Easily Winded	Yes	No
Rheumatic Fever	Yes	No	Coronary Artery Stent	Yes	No	Stroke	Yes	No
Swollen Ankles	Yes	No	Angina	Yes	No	Hay Fever	Yes	No
Fainting/Seizures	Yes	No	Frequently Tired	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Anemia	Yes	No	Radiation Therapy	Yes	No
Low Blood Pressure	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Epilepsy/Convulsions	Yes	No	Cancer	Yes	No	Bisphosphonate Therapy		
							Yes	No
Leukemia	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Joint replacement or implant	Yes	No	Heart Trouble	Yes	No
Kidney Disease	Yes	No	Hepatitis/Jaundice	Yes	No	Respiratory Problem	Yes	No
AIDS or HIV Infection	Yes	No	Sexually Transmitted Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Thyroid Problem	Yes	No	Stomach Troubles/Ulcers	Yes	No	Other: _____		

2. Are you under medical treatment now? Yes No
3. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
4. Are you taking any medications, including nonprescription medications? Yes No
If yes, which medications are you taking? _____
5. Have you ever taken Phen-Fen/Redux? Yes No
6. Do you use tobacco? Yes No
7. Do you use controlled substances? Yes No
8. Women Only:
Are you, or do you think you may be pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No
9. Are you allergic to or have you had any reactions to:

Latex Rubber	Yes	No
Local Anesthetics (eg Novocaine)	Yes	No
Penicillin or other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Any Metals (eg nickel, mercury)	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Other _____	Yes	No
10. Do you have, or have you had any disease, condition, or problem not listed? Yes No
If yes, please explain: _____

PATIENT DENTAL HISTORY

Name of previous Dentist and Location: _____ Date of last Exam: _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold? Yes No
3. Are your teeth sensitive to sweet or sour? Yes No
4. Do you have any tooth pain? Yes No
5. Do you have sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw:

Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening and closing	Yes	No
Difficulty in chewing	Yes	No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks? Yes No
11. Have you ever had a difficult extraction? Yes No
12. Have you ever had any prolonged bleeding following and extraction? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials Yes No
If yes, date of placement _____
15. Have you ever received oral hygiene instruction regarding the care of your teeth and gums? Yes No

Smile Questionnaire

Please rate your smile on a scale of 1 to 10 with 10 being the best.

1 2 3 4 5 6 7 8 9 10

If you had a magic wand, what would you change about the appearance of your teeth and smile?

Whiter Straighter Longer Shorter
Less Crowded Close the Gaps Less "gummy" Smile Other _____

What can we do to make your visit more pleasant?

OUR OFFICE FINANCIAL POLICY

It is customary for us to receive full payment at the time of the appointment for the INITIAL EXAMINATION and CONSULTATION appointment, as well as for EMERGENCY VISITS. When extensive treatment is planned, requiring multiple appointments, we realize it may be necessary to make other arrangements before the treatment is scheduled.

How will you be paying for your treatment? Please circle one:

Cash Check Credit Card Debit Card

Would you be interested in finding out about extended payment options? Yes No

For patients with a dental benefit covering part of the treatment cost:

Dental benefits are a money benefit typically provided by an employer to help their employees pay for routine dental treatment. Most benefit plans are only designed to cover a portion of the cost. We ask for your co-payment for each service at the time it is rendered.

As a courtesy to our patients with dental benefits we will:

- 1) Complete your claim forms and submit them to your carrier within 24 hours of treatment.
- 2) Use current American Dental Association coding for correct reporting of procedures.
- 3) Accept direct payment from your primary carrier.
- 4) If necessary, refile your claim a second time within a 60 day period.

Patient Responsibilities

- 1) Pay fees not covered by your plan at the time of treatment.
- 2) Provide our office with correct information regarding your benefit plan.
- 3) In the event that you may be covered by two dental benefit plans, we will await payment from your primary plan, but ask that your secondary plan reimburse you directly.
- 4) Understand that your plan is between you and your employer and carrier. Our office does not have the power to make your plan pay.
- 5) Pay any account balance not covered by your benefit plan, or not received by our office within 60 days of treatment.

In the event of an outstanding balance, a 1.5% finance charge will be assessed monthly. Also, we reserve the right to charge a fee for missed appointments if not given at least 48 hours notice of cancellation.

Our office manager and receptionist are responsible for scheduling your appointments and completing your financial arrangement. They will sincerely consider your needs in each of these areas and make special arrangements if necessary. If you have any questions about the above, please do not hesitate to consult with them. Thank you for your cooperation.

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of changes in dental benefits, address, phone numbers, and medical conditions. I have read and understand the above policy and fully intend to stand by the financial arrangements made with the office.

Signed: _____ Date: _____