NORTHBROOK DENTAL CARE, LLC.

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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: _______________________________

Check Appropriate Category: ____ Married ____ Single ____ Divorced ____ Separated

Social Security #: _______________________ Birth Date: ________________

Address: _________________________________ City: ___________________ State: _____ Zip: __________

Home Phone: _____________________ Work Phone:________________ Cell Phone: ______________________

Email 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: _________________ Social Security # ________________ Birth Date:____________

Home Phone: _________________ Work Phone: _______________ Cell Phone: ____________________

Address: ____________________________________ City: _______________ State: ________ Zip: ________

Is This Person Currently a Patient in Our Office? ___Yes ___No

DENTAL INSURANCE 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	Heart Murmur	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	Recent Weight Loss	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

What can we do to make your visit more pleasant?

____

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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. We have the following options available for you:

For patients with insurance covering part of the treatment cost:

We ask for your copayment for each service at the time it is rendered. We will complete and send whatever pre-treatment information and estimation is required, and send your insurance forms in for payment as each phase of treatment is completed. We will await the insurance check for 60 days. If payment from the insurance company is not received, we will notify you and ask for payment from you. Your insurance company will then pay you directly.

For patients with no insurance coverage or patients whose copayments are greater than $500.00:

1. Payment in full by check or credit card for the entire treatment plan prior to first visit. A 5% discount is given for treatment ranging between $500.00 and $1,500.00. An 8% discount is given for treatment over $1,500.00.
2. Cost of entire treatment plan divided into 3 equal payments. First payment made at first treatment visit, second payment made at last treatment visit. Third payment made at last treatment visit by post-dated check or credit card voucher.
3. Payments are divided equally over number of treatment visits. The total treatment plan amount is divided by the estimated number of treatment visits and equal payments are made at each visit.
4. Payments are made over several months. 0% financing is available for 3, 6, or 12 months through an outside finance company. Our dental office pays the interest. Subject to credit approval.
5. Extended payment option. The above company also offers 24 and 36-month payment plans. The patient pays all the interest. Subject to credit approval.

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 insurance, 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: ____________________