PATIENT INFORMATION

First Name _____Last Name _____Initial _____

PATIENT IS: ___Policy Holder Preferred Name _____

___Responsible Party Whom may we thank for referring you to our office? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name _____Initial _____

Address: _____City, State, Zip _____

Home Phone: _____Work Home: _____Ext.: _____Cellular _____

Sex: _____Male ____Female Marital Status: ___Married ___Single ___Divorced _Separated _Widowed_____

Birth Date: _____Soc. Sec. _____Drivers Lic: _____

Email: _____

Employment Status: ___Full ___Part Time ___Retired

Student Status: ___Full ___Part Time

Patient Information

Address: _____City, State, Zip _____

Home Phone: _____Work Home: _____Ext.: _____Cellular _____

Sex: ____Male _____Female Marital Status: ___Married ___Single ___Divorced _Separated _Widowed_____

Birth Date: _____Soc. Sec. _____Drivers Lic: _____

Email: _____

Employment Status: ___Full ___Part Time ___Retired

Student Status: ___Full ___Part Time

Primary Insurance Information

Name of Insured_____Relationship to Insured: ____Self ___Spouse ____Child ___Other

Insured Soc. Sec: _____Insured Birthday: _____

Employer: _____ Address: _____

Ins. Company: _____ Address: _____

Remaining Benefits: _____Remaining Deductible _____Group # _____Insured ID # _____

Secondary Insurance information

Name of Insured_____Relationship to Insured: ____Self ___Spouse ____Child ___Other

Insured Soc. Sec: _____Insured Birthday: _____

Employer: _____ Address: _____

Ins. Company: _____ Address: _____

Remaining Benefits: _____Remaining Deductible _____Group # _____Insured ID # _____

Medical/Dental History

Patient Name _____ Date of Birth _____

Although dental personnel primarily treat the in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication you might be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physicians care now?	Yes	No	If yes, please explain: _____
Have you been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, Please explain: _____
Are you taking any medication, pills or drugs?	Yes	No	If yes, Please explain: _____
Do you take or have you taken Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use a controlled substance?	Yes	No	

Woman: Are You …

Pregnant/Trying to get pregnant? Yes No Taking Contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes please explain _____

Do you have, or have you had any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	no
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting or Dizziness	Yes	No	Kidney Problems	Yes	No	Intestinal Disease/Stomach	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain In Jaw joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes explain: _____

Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

NOTICE OF PRIVACY PRATICE ACKNOWLEGEMENT

I understand, that under the Health Insurance and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment, or health care operations. I also understand you are not required to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Chicago Bright Smiles

1920 N. Lincoln Ave.

Chicago, IL 60614

312-642-5107

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below:

Date:	**Initials:**	**Reason:**

Chicago Bright Smiles Written Financial Policy

Thank you for choosing Chicago Bright Smiles. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- ☐ _____Visa, Master Card, American Express, Discover Card, Cash or Check
- ☐ _____We Offer a 5% courtesy accounting adjustments to patient who pay for their treatment with cash prior to completion of care for treatment plans of $1000 or more.
- ☐ _____NO INTEREST payment plans from CARECREDIT or CHASE
    - Allow you to pay over time with no interest
    - Convenient Low monthly payment plans also available
    - No annual fees or pre payment penalties

Please note:

Chicago Bright Smiles Requires payment prior to the completion of your treatment, if you choose to discontinue care before treatment is complete your refund will be determined upon review of you case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with you and your carrier to maximize your benefit and directly bill them for reimbursement of your treatment.

Please note that you are ultimately responsible for any balance not covered by your insurance carrier and will be billed according to your plan.

Estimated co-payments are due at the time of service unless other financial arrangements have been made.

A fee of $50 is charged to patients who miss or cancel without a 24hr notice to office.

Chicago Bright Smiles charges a $30 fee for returned checks

Patient, Parent, or Guardian Signature_____ Date_____

Patient Name Please Print: _____