Yorkville Family Dental

HEALTH HISTORY

PATIENT INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ GENDER: MALE/ FEMALE

MARITAL STATUS: MARRIED / SINGLE / DIVORCED / OTHER

ADDRESS: _____CITY/STATE/ZIP: _____

HOME PHONE #:_____ OTHER PHONE #:_____ Wk./Cell/Other

EMPLOYER: _____ EMAIL ADDRESS: _____

How did you find out about our office? Friend Website Insurance List Ad Other

Is there anything about your smile you'd like to change? _____

INSURANCE INFORMATION

Insurance Name: _____ **Insurance Phone#** _____

Subscriber: _____ **DOB:** _____

Subscriber's ID/SS# _____

MEDICAL HISTORY

What is the approximate date of your last doctor's visit? Month Year

Do you have a physician or family doctor? Yes No

If yes, please list name, address and phone number

How do you rate your current physical health? Good Fair Poor

Are you under medical treatment now? Yes No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, please list

Have you ever taken prescription medication for weight loss (diet pills)? Yes No
If so, did you take any of the following: __Fen-Phen (Fenfluramine-Phentermine) __Redux (Dexfenfluramine)
__Pondimen (Fenfluramine) __Don't remember
__Other

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

__High blood pressure	__Joint replacement or Implant	__Hemophilia, abnormal bleeding
__Low blood pressure	__Respiratory problems	__AIDS or HIV
__Heart attack	__Asthma	__Leukemia
__Rheumatic fever	__Hay fever/Allergies	__Emphysema
__Heart disease	__Thyroid problems	__Cancer
__Pacemaker	__Diabetes	__Chemotherapy

__Heart murmur
__Mitral valve prolapses
__Angina
__Chest pains
__Stroke
__Arthritis
__Swollen ankles
__Kidney disease
__Liver disease
__Stomach troubles/Ulcers/Colitis
__Fainting/Seizures
__Epilepsy/Convulsions
__Easily winded
__Frequent headaches
__Radiation therapy
__Hepatitis/Jaundice
__Sexually transmitted disease (STD)
__Tuberculosis (TB)
__Glaucoma
__Other
__None of the above

****Are you allergic to or have you had any reactions to the following?**
__Local anesthetics (e.g. Novocain)
__Sedatives, dental anesthetics
__Penicillin or any other antibiotics
__Aspirin
__Erythromycin
__Tetracycline
__Codeine
__Sulfa drugs
__Barbiturates
__Iodine
__Any metals (e.g. nickel, mercury, etc...)
__Latex rubber
__Other
__None of the above

Do you smoke or use tobacco? Yes No
If yes, specify how many packs per day

Do you use controlled substances? Yes No

Women only: Please select all that apply to you.
__Pregnant or think you may be pregnant
__Nursing
__Taking oral contraceptives (birth control pills)
__None of the above
If you are pregnant, how many weeks?

DENTAL HISTORY

What is the reason for you visit? Check-up Toothache Teeth/Gums Hurting or Bothering Me Other

When was the last time you were seen by a dentist for a complete dental examination and/or teeth cleaning?
Month Year

How often do you have dental examinations?
__Twice per year
__Once per year
__Once per 2 years
__Once per 3 years
__More than three years between exams
__This is the first time

How many times a day do you brush your teeth?

How many times a day do you floss?

What type of toothbrush do you use? Manual Electric Both

Do you have anything listed below?
__Sores or lumps in or near your mouth
__Gums bleed while brushing or flossing
__Food tend to become caught in between teeth
__Clench or grind teeth
__Bite lips or cheeks frequently
__Breathe through mouth while awake or asleep
__Have tired jaws, especially in the morning
__Feel pain to some teeth
__Any other dental problems
__None of the above

Have you ever had any of the following?
__Oral surgery
__Periodontal treatment
__Gum therapy
If yes, please describe
__Your teeth ground or the bite adjusted
__A bite plate or mouth guard
__A serious injury to the mouth or head
__None of the above

***Have you ever experienced any of the following?**

__Clicking or popping of the jaw
__Pain in joint, ear, side of face
__Difficulty in opening or closing the mouth
__Difficulty in chewing on either side of the mouth
__Headaches, neck aches or shoulder aches
__Sore muscles (neck, shoulders)
__Had difficult tooth extraction in the past
__Had prolonged bleeding following tooth extractions
__None of the above

Are your teeth sensitive to any of the following? Hot/Cold Sweets Biting/Chewing

Do you hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails, etc....)? Yes No

Have you ever had any history of orthodontic treatment (braces, retainer, etc....)? Yes No
If yes, please specify when it was done

Do you wear dentures, partials or are you using any other dental devices? Yes No
If yes, please specify what kind and when they were placed

Have you ever received oral hygiene instruction regarding the care of your teeth and gums? Yes No

Do you like your smile? Yes No

Are you interested in doing cosmetic treatment?
(For example: teeth whitening, straightening teeth, changing smile) Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

__I Agree __I Disagree

Signature_____ Date_____

Yorkville Family Dental
Compliance Assurance Notification For Our Patients
HIPAA

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethic and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan we have implemented a Compliance Program that we believe will help us prevent from any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we many remedy the situation promptly.

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain helath care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health informantion, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this documentation, at some future time you may request to refuse all or part of your PHI. You many not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____	_____	_____
Signature	Print Name	Date

Yorkville Family Dental
Gentle, Trusted Care
Ricardo Laguatan, DDS
2621 Bridge St. Yorkville, IL. 60560
630-385-3111

OFFICE POLICIES

Thank you for choosing Yorkville Family Dental as your dental healthcare provider. We are committed to providing the highest quality of care possible. In order to concentrate on patient care, we have implemented the following office policies.

Self Pay Patients:
Full payment is due at the time of service, unless other payment arrangements have been made in advance. For your convenience we accept cash, personal checks and most major credit cards.

Insurance Patients:
Insurance Name:_____ Insurance Phone#_____
Subscriber: _____ DOB: _____
Subscriber's ID/SS#_____
The estimated patient portion is due at the time of service. As a courtesy to you, we will submit all insurance claims and necessary information to your insurance company for reimbursement. You are responsible for any balance not covered by your insurance including deductibles or amounts not considered usual and customary.

Usual and Customary: Dr. Laguatan is committed to providing the most cost effective treatment possible, and charges fees which are reasonable for this area. Often times, insurance companies assign fees in which they determine is "usual and customary". Often their fees are not based on geography, and are often unrealistic or arditrary.

Extended Payment Plans: For your convenience we participate in "Care Credit". This is an interest free or low interest credit plan which offers a variety of payment options. Following completion of a very brief application form, approval is usually verified within minutes.

Past Due Accounts: A finance charge of 1.5% monthly will be applied to any past due account. Past due accounts are referred to a collection agency, and a collection processing fee of $25 will be added to your account.

Cancellation Policy: Please give 24 hours prior to cancelling an appointment. We understand that occasionally appointments are forgotten or broken (missed), however, after your second broken appointment you will be charged a fee $25 for that and any future broken appointment.

I, the undersigned, have read and agree to the terms of these Office Policies.

Signature:_____ Date:_____

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SIGNATURE ON FILE

I hereby authorize payment directly to the dental practice listed above of the dental benefits otherwise payable to me. I understand my signature is valid for two years from the above date, unless revoked by me at an earlier date.

The above listed dental practice and its staff is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advise, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request.

Comments:_____

_____

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Signature:_____ Date:_____