Welcome to our Practice

PATIENT INFORMATION:

Today's Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Soc. Sec. #_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist_____ (FIRST NAME) _____ (LAST NAME) Orthodontist_____ (FIRST NAME) _____ (LAST NAME) Medical Dr._____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.#_____ Nearest relative not living with you_____ (FIRST NAME) _____ (LAST NAME) Tel.(_____)_____

Employer_____ Bus. Tel.(_____)_____ Personal Payment Type: ❑ Cash ❑ Credit Card

In case of emergency, please contact_____ Tel.(_____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME) _____ (LAST NAME) S.S.#_____ Birth Date_____ Age_____

Tel.(_____)_____ Cell.(_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Driver's Lic.#_____ Employer_____ Bus. Tel.(_____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME) _____ (LAST NAME) Relation_____ S.S.#_____ Birth Date_____

Street_____ Apt._____ City_____ State_____ Zip_____

Tel.(_____)_____ Employer_____ Bus. Tel.(_____)_____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address_____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not. . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
10. Rheumatic fever?			
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea?			
24. Difficult breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs a day _____			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells?			
37. Convulsions / epilepsy?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers / acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue / night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems / anxiety / depression?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 64–67)*

		Yes	No
64.	Is there a possibility of pregnancy?	❑	❑
65.	Expected delivery date? _____		
66.	Are you nursing?	❑	❑
67.	Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

AVILA DENTAL

FINANCIAL AGREEMENT

Thank you for choosing Avila Dental as your dental care service provider. We are committed in providing the best dental care service available to you and your family. In our continuous effort to attend all of your dental needs, our finance department is here to assist and answer any questions you might have regarding our service fees and review this policy agreement with you.

We ask that the patient or the responsible party reads and signs Avila Dental's financial agreement and that all patient questionnaires are completed before seeing the dentist.

Payments are due at the time that services are being rendered. To serve you better, we accept payments in the forms of cash, personal checks, Visa, MasterCard, Discovery and American Express. As a courtesy to you, it is our policy to send the bill to your dental insurance even though that you are the responsible party for the entire bill. Carefully read the following statements:

(PLEASE INITIAL EACH OF THE FOLLOWING AGREEMENTS)

_____ 1. Dental insurance is a contract between you, your employer and the insurance company. Avila Dental is not part of this contractual agreement. The relationship is with you and not with your insurance company. We will not participate in any conflicts regarding deductibles, co-pays, open charges, a secondary insurance and any "usual and customary" fees with your insurance company. As your provider, we will only provide truthful, correct and objective information to facilitate the claim process.

_____ 2. Service fees, which may include open balances, deductibles and/or co-payments, are due at the time of service. Returned checks (a $30 NSF fee will be added) and open balances will be referred to a collection agency.

_____ 3. Even if your insurance pays or not, remember that all service fees are your responsibility. If your insurance company does not send payment within 60 days, you are responsible party for the balance. If payment was made directly to you and billed to your insurance by Avila Dental, you are under the obligation to forward such payments to Avila Dental.

_____ 4. I understand and agree that if I do not make any of the payments for which I am responsible, Avila Dental will forward my information to a collection agency or to an attorney and that I will be responsible for any fees incurred, including the costs associated with the collection process, court costs, and service fees due to the collection agency or attorney.

_____ 5. The aforementioned is not applicable to patients receiving worker's compensation benefits. Nevertheless, be mindful that even as a patient receiving worker's compensation benefits, you can be made responsible for the fees in the case that your claim is denied. .

At Avila Dental, we understand that financial difficulties may occur and can affect your ability to make timely payments. In such cases, we recommend that you communicate any such circumstances in order to assist you in maintaining your account up to date.

Avila Dental reserves the right to charge up to $100.00 for a missed appointment fee. An appointment is considered broken when the patient does not show up for their appointment or cancels and reschedules an appointment within a 24 hour period. Please be mindful that scheduled appointments are specially saved for you. Your 24 hour advance notice permits us to schedule and treat other patients who are waiting for an appointment.

BENEFITS DESIGNATION AND PERIMISSION TO RELEASE INFORMATION

I authorize that the insurance benefits be paid directly to Avila Dental and also agree that I am responsible for any charges not covered by my insurance. I also authorize Avila Dental to release any dental treatment information to my insurance company.

I have read and understand the information that was aforementioned and that I am the responsible party for the following patient:

_____ _____

Patient's Name Date of Birth

_____ _____

Patient's or Responsible Party's Signature Date

6144 S. Pulaski Rd. , Chicago, IL 60629 • 773-585-8000

Is there a family history of:

	Yes	No
68. Cancer?	☐	☐
69. Diabetes?	☐	☐
70. Heart disease?	☐	☐
71. Anesthesia problems?	☐	☐

Are you now taking:	Yes	No	NOTES
72. Any kind of medication, drug, pills?			
73. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
74. Have you ever taken diet pills?			
75. Any natural product, herbal supplement or homeopathic remedy?			
76. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV–Zometa, or Aredia in the past 12 years?			

77. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

78. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Are you allergic to, or had a reaction to:	Yes	No	NOTES
79. Local anesthetic (numbing meds.)?			
80. Penicillin?			
81. Other antibiotics?			
82. Sulfa drugs?			
83. Sodium pentothal / Valium / other tranquilizers?			
84. Aspirin?			
85. Amoxicillin?			
86. Codeine or other narcotics?			
87. Other medications?			
88. Latex?			
89. Soy?			
90. Eggs / yolk?			
91. Sulfites?			
92. Do you have any known allergies?			

93. Please list any allergies other than drug allergies:

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other staff member, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney's fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

AUTHORIZATION

I authorize my doctor and/or designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Witness**

X _____ **Doctor**

X _____ **Date**

I hereby acknowledge that a copy of this office's notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if minor)*

X _____ **Date**