NORTH SUBURBAN
DENTAL

ADULT REGISTRATION FORM

PATIENT INFORMATION

Date _____

Patient Name _____ I prefer to be called _____
LAST, FIRST, M.I.

Date of Birth _____ Social Security # _____

Gender ❒ Male ❒ Female Driver's License # _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Employer _____

Email _____

Emergency Contact _____ Emergency Phone _____

Person Responsible for Account _____ Relationship to Patient _____

How did you hear about our office?

- ❒ Friend/Relative
- ❒ Mailing
- ❒ Social Media Site _____
- ❒ Computer Search
- ❒ Dental Insurance
- ❒ Current North Suburban Dental Patient

Who may we thank for referring you? _____

Has any member of your family been treated in our office? ❒ No ❒ Yes _____

DENTAL INSURANCE INFORMATION

Please provide front desk with a copy of your insurance card.

PRIMARY INSURANCE

Name of Insured _____ Date of Birth _____
LAST, FIRST

Employer _____ Insurance Co _____

Subscriber ID or SS# _____ Group # _____

Insurance Phone _____

SECONDARY INSURANCE

Name of Insured _____ Date of Birth _____
LAST, FIRST

Employer _____ Insurance Co _____

Subscriber ID or SS# _____ Group # _____

Insurance Phone _____

DENTAL HISTORY

Date of last dental visit _____ Did you bring x-rays? ❒ Yes ❒ No

Reason for today's visit _____

Why did you decide to change dental offices? _____

Is there anything in your mouth or about your smile that you would like to change or modify? ❒ Yes ❒ No

If yes, please specify _____

How do you rate your dental health ❒ Good ❒ Fair ❒ Poor
Do your gums bleed when you brush? ❒ Yes ❒ No
Do you use an electric toothbrush? ❒ Yes ❒ No
Do you smoke or use chewing tobacco? ❒ Yes ❒ No
Have you been treated for ❒ Orthodontics ❒ Periodontal Disease ❒ Sleep Apnea or Snoring
Are you afraid of the dentist or have you had a bad experience? ❒ Yes ❒ No

Check if you have or do any of the following

- ❒ Bad Breath
- ❒ Blisters on Lips/Mouth
- ❒ Clenching of Teeth
- ❒ Grinding Teeth
- ❒ Food Collecting Between Teeth
- ❒ Sensitivity to Biting
- ❒ Sensitivity to Sweets
- ❒ Sensitivity to Hot/Cold
- ❒ Headaches
- ❒ Dry Mouth
- ❒ Mouth Breather
- ❒ Jaw Pain
- ❒ Clicking/Popping Jaw
- ❒ Broken/Loose Teeth or Filling
- ❒ Missing Teeth
- ❒ Sores/Growths
- ❒ Ear Pain

MEDICAL HISTORY

Are you currently under a physician's care? ❒ Yes ❒ No If yes, for what? _____

Physician's Name _____ Phone # _____

List medications you are taking _____

_____

Check any medical conditions you have or have had

- ❒ Heart Disease
- ❒ Shortness of Breath
- ❒ Pacemaker
- ❒ Rheumatic Fever
- ❒ Heart Murmurs
- ❒ Stroke
- ❒ Bleeding or Clotting
- ❒ Major Surgery
- ❒ Diabetes
- ❒ Thyroid Problems
- ❒ Respiratory Problems
- ❒ Psychiatric Issues
- ❒ Nervous Disorders
- ❒ Liver Disease
- ❒ Kidney Disease
- ❒ Fainting or Dizziness
- ❒ Cancer
- ❒ Radiation
- ❒ Chemotherapy
- ❒ Shingles
- ❒ Arthritis
- ❒ Blood Disorders
- ❒ Sleep Apnea
- ❒ Abnormal Blood Pressure
- ❒ Glaucoma
- ❒ Osteoporosis
- ❒ Artificial Joints
- ❒ Hepatitis
- ❒ Asthma
- ❒ COPD
- ❒ Epilepsy or Seizures
- ❒ HIV/Aids

Are there any other medical issues or conditions not listed that we should know about? _____

_____

Do you have any allergies or had a negative reaction to

- ❒ Local Anesthetic
- ❒ Metal/Nickel
- ❒ Sulpha Drugs
- ❒ Acrylic/Plastic
- ❒ Codeine
- ❒ Antibiotics _____
- ❒ Latex

Do you have any other allergies that we should know about? _____

Do you generally take antibiotics before a dental visit? ❒ Yes ❒ No

Women Are you pregnant or trying to get pregnant? ❒ Yes ❒ No
Are you nursing? ❒ Yes ❒ No
Are you on birth control pills? ❒ Yes ❒ No

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

∗ Signature of Patient/Guardian _____ **Date** _____

CONSENT FOR TREATMENT

I authorize the doctor or designated staff to take x-rays, study models and any other diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I also authorize photographs for the purpose of illustration or publication in professional journals or the advancement of teaching. I have been informed that patient identity will be protected at all times.

Upon diagnosis, I authorized the doctor and/or hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.

I agree to the use of anesthetics, including nitrous oxide, and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs, which I may be taking in order to minimize these risks.

∗ Signature of Patient/Guardian _____ **Date** _____

FINANCIAL AND OTHER POLICIES

Payment I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collect only the **estimated** co-payment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected co-payment from historical data. If you want a more accurate estimate, ask to have a **pretreatment estimate** sent to your insurance company. We will gladly submit your insurance claim to your insurance. If we do not get paid within 30 days of submission of the claim we will look to you for full payment of your bill. Once we reach your annual maximum benefit, we will look to you for complete payment at the time of service unless a written payment plan has been made. We accept cash, checks, money orders and all major credit cards for your payments.

A service charge of 1.5% per month (18% per annum), but in no event more than the maximum rate permissible under state laws, will be charged on the unpaid principle balance on all accounts not paid within 60 days of the treatment date. I further understand the fee estimates listed for my dental care can only be extended for a period of six months from the date the estimate was written.

After 90 days from the date of service any unpaid accounts will be referred to a collection agency. I will then be responsible for my balance plus an additional 30% of the unpaid balance as the agency fee and any attorney's fees. I grant my permission to you, or your assigns, to phone me at my home or place of employment to discuss matters related to this form, my treatment or billing issues.

Assignment of Benefits I authorize my insurance company to pay directly to North Suburban Dental, benefits accruing to me under my policy. I understand that I am responsible for any charges not covered by my insurance.

Do not sign this if you have any questions about the financial or other policies of our offices. If you have any questions, ask one of our financial coordinators before signing this paper.

I have read the above Financial and Other Policies and agree to the content.

∗ Signature of Patient/Guardian _____ **Date** _____

North Suburban Dental Acknowledgment of Receipt of Notice of Privacy Practices Please notify the front desk if you refuse to sign this Acknowledgment.

I, _____ have received a copy of the office's Notice of Privacy Practices.
PRINT NAME

∗ Signature of Patient/Guardian _____ **Date** _____

NORTH SUBURBAN
DENTAL

PATIENT PRIVACY AUTHORIZATION

INDIVIDUAL PATIENT

I, _____ give my authorization to use or disclose my or my child's protected health information as described below.

USE AND DISCLOSURE

I understand that under HIPAA regulations, my dental/health information related to services rendered will be used and disclosed to any dental/health care provider who is involved with my or my child's dental/medical health treatment or services, my dental/medical insurance plan and any dental/medical billing clearinghouse who is involved with my insurance claim fulfillment.

Under these regulations, **the following people must be authorized by you to have access to your dental/health information** — your spouse; other family members and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your dental/medical treatment, insurance plan or payment.

Please list the people that you authorize to have access to your information.

Name _____ Phone _____

Address _____ Relationship to Patient _____

CIty _____ Zip_____

Specific information to disclose _____ Expiration date of disclosure _____

Name _____ Phone _____

Address _____ Relationship to Patient _____

CIty _____ Zip_____

Specific information to disclose _____ Expiration date of disclosure _____

CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your office.

METHOD OF CONTACT

I authorize the office of North Suburban Dental to contact me in the following manner.

❒ Home Phone _____

❒ Leave message with detailed information ❒ Leave message with call back number only

❒ Work Phone _____

❒ Leave message with detailed information ❒ Leave message with call back number only

❒ Cell Phone _____

❒ Leave message with detailed information ❒ Leave message with call back number only

❒ Email _____

❒ Written Mail _____

STATEMENT OF UNDERSTANDING

I have reviewed and I understand this authorization. I also understand that my or my child's dental/health information will be used or disclosed to certain business associates who are a part of the dental/health care process. These business associates will also keep your health information confidential.

∗ Signature of Patient/Guardian _____ **Date** _____