Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Northfield Dental Office

Northfield Dental Office
1721 Orchard Lane
Northfield, IL (847) 441-5335

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: ( ) _____ Email: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of our protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at any time by contacting:

Contact Person:	David S. Titus, DDS
Telephone:	847-441-5335 Fax: 847-441-5339
Email:	northfielddental@sbcglobal.net
Address:	Northfield Dental Office 1721 Orchard Lane Northfield, IL 60025

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of our revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your healthcare needs. We will never sell or share your health information.

SIGNATURE:

I, _____, have full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I a giving my consent to your use and disclosure of y protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a person representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Northfield Dental Office

Northfield Dental Office
1721 Orchard Lane
Northfield, IL (847) 441-5335

FINANCIAL POLICIES AND MISSED APPOINTMENT POLICIES

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the office manager. Thank you.

INSURANCE: We are happy to bill both your primary and secondary insurance carriers as a courtesy for our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.
2. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help speed things up.
3. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, MasterCar4d, Discover, American Express or Visa.
4. We will do our best to estimate insurance coverage and patient portions due (we will send pre-estimates for services over $500 at your request. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 10 days after the statement date.

PATIENT PAYMENT: Payment is due at the time services are rendered. For larger cases, 50% of the patient portion is due at the start of treatment, including any deductible and the remaining 50% at the last appointment. We accept cash, checks, and all major credit cards. We also offer CARE CREDIT as an option. Balances over 60 days will incur an interest charge of 1.5% per month and after 90 days, an additional $5.00 rebilling fee per statement will be charged. Returned checks will have an additional fee of $25.00 added to the amount of the returned check. Please contact the office manager for more information on any of the above payment options.

NO SHOW/MISSED APPOINTMENTMENTS: We request notice of 48 hours for cancellation of appointments. If appropriate notice is not given, a charge of $50 may be assessed to the patient's account. For appointments longer than 1 hour, the charge will increase, i.e., $75.00 for a two hour appointment, $100.00 for a 3 hour appointment or on any Saturday appointment. We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the dentist.

REFUNDS FOR UNFINISHED TREATMENT: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist.

CREDITS ON AN ACCOUNT: If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave a credit on the account to be applied towards future treatment.

1. I would like to pay by cash, check, debit or credit card at the time of service. X _____
2. I would like to apply for an extended payment plan for treatment over $1,000 through Care Credit. X _____

I have dental insurance:

1. I would like to pay y estimated portion by cash, check, or credit card at the time of service. X _____
2. I would like to apply for an extended payment plan for treatment over $1,000 through Care Credit. X _____

Date: _____

Patient Name: _____ Patient Signature: _____

Guarantor Name: _____ Guarantor Signature: _____

Our office reserves the right to make changes without notice.

Northfield Dental Office
1721 Orchard Lane Northfield, IL (847) 441-5335

Professional Teeth Whitening for Life Program is a courtesy and a privilege compliments of Northfield Dental. This program is extended to patients who have proven themselves as individuals who take their oral hygiene care and general dental health seriously. We believe it is extremely important to maintain recommended hygiene care appointments and receive necessary dental treatment to maintain a healthy and beautiful smile. In fact, patients who maintain regular hygiene appointments and receive recommended treatment spend less money on dental care (on average) than those who only see the dentist when they perceive a problem exists. All too often, people who wait until there is a problem have irreversible damage to their gums, teeth, and/or jaw.

We pride ourselves on the smiles that leave our practice. We also pride ourselves on knowing our patients are maintaining the best possible oral health. **Professional Teeth Whitening for Life Program** was developed as a free* gift for those patients that are already taking their dental health seriously, and as an incentive for those who need a little keeping up with their dental care. Patients will receive custom made, professional, take home whitening trays for personal use.

This privilege does require some rules, restrictions, and regulations. Below is a brief description of the qualifiers for this program. Please read through them carefully. You will receive a copy of our Broken Appointment Policy. Please review the policy and sign below, acknowledging receipt and understanding of compliance of said policy. While **Professional Teeth Whitening for Life Program** is a gift from us to you, we insist that all rules and regulations are followed in order to receive and continue to receive this benefit. Should any of the rules or regulations fail to be met, you will immediately be disqualified from the program until you have successfully met all of the qualifying rules for a minimum of twelve months.

New Patient Activation Rules and Regulations:

1. Must be at least 18 years of age.
2. Must complete initial hygiene, x-rays, doctor's exam, and re-appoint for six-month re-care.
3. Must comply with minimum required dental care treatment planned by the doctor.
4. After all necessary dental treatment has been completed, patient will have impressions taken for their custom bleaching trays and be charged a *one-time enrollment fee of **$160.00**
5. Upon next appointment, patient will receive their Professional Teeth whitening package*.
6. Must comply with broken appointment policy.
7. Must not have any outstanding bills with Northfield Dental.

Existing Patient Activation Rules and Regulations:

1. Must be at least 18 years of age.
2. Must comply with minimum required dental care treatment planned by the doctor**. After all necessary dental treatment has been completed, patient will have impressions taken for their custom bleaching trays and be charged a *one-time enrollment fee of **$160**
3. Must comply with broken appointment policy.
4. Must not have any outstanding bills with Northfield Dental.
5. Must have at least six months patient history without any broken appointments or late arrivals, and re-appoint for six-month re-care.

Lifetime Maintenance Rules and Regulations:

1. Must maintain minimum continued care as treatment planned and appointed by Northfield Dental, its doctors, and staff.
2. Must maintain continued hygiene care (six-month hygiene appointments).
3. Must comply with all Northfield Dental policies regarding payment and broken appointments.
4. A maximum of one whitening solution refill syringe will be rewarded annually.
5. Lost or destroyed applicator trays will be replaced at cost to patient.

*There is a one-time enrollment fee of **$160.00** that is due when the impressions are taken for your custom bleaching trays.
**All patients will receive their whitening package upon completion of all necessary dental treatment as determined by the dentist. Should no dental treatment be required to maintain healthy teeth and gums, the total whitening package will be received upon completion of follow-up visit (typically six months). Minimum gum and teeth health required to receive professional whitening in order to prevent complications that may arise with unhealthy teeth and gums.

Disclaimer: Northfield Dental, its doctors and staff have the right to refuse offer if deemed necessary based on patient health conditions, misuse, abuse, or any other factor deemed necessary to void offer.

I, _____ hereby certify that I agree to the terms and conditions outlined above. I also acknowledge receipt of Northfield Dental's Broken Appointment Policy. I understand that the "Free Professional Teeth Whitening for Life Program" is a privilege only bestowed to individuals who meet and maintain all of the rules and regulations pertaining to said program.

_____ _____

Signature **Date**