PATIENT MEDICAL HISTORY

Patient Name:	For Office Use Only ID:	
Address:	Today's Date:	Date of Last Visit:
City State Zip:	Email:	

Home Phone:	Cell Phone:	Birth Date:	Social Security #:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:
Secondary Dental Guarantor:	Home Phone:	Work Phone:

Physician Name:	Physician Phone:
Pharmacy:	Pharmacy Phone:

* For Office Use Only Medical Alerts:

Sex:

M F

Y N
☐ ☐ Do you smoke or use tobacco?

If female:
Y N
☐ ☐ Are you pregnant?

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Tetracycline
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Dental Anesthetics

Other
____
____
____
____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Signature

X______________________________

ORLAND SMILES

Patient Information

Patient Name:____________________________ **Date of Birth:**_____________

Account Information

If Patient is a Minor, Parent's Name____________________________

Who is responsible for the account? ____________________________

Emergency Contact Information

Name:________________________ Relationship:_____________ Phone Number:________________

Primary Insurance Information

Insurance Company:________________ Policyholder:__________________

Policyholder Date of Birth:___________ Policyholder SSN:_________________

Policyholder Employer:____

Secondary Insurance Information

Insurance Company:________________ Policyholder:__________________

Policyholder Date of Birth:___________ Policyholder SSN:_________________

Policyholder Employer:____

Referal Information

__Online Ad __Newspaper Ad __Other ____________________

__Orland Smiles Employee, Employees Name___________________

__Patient, Patients name__________________

RELEASE: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist. I authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than that of the actual bill for services. I understand that I am financially responsible for payments in full of my account. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole, or in any part by my dental care payor.

____ __________________________

Patient or Guardian's Signature **Date**

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Please list any medications you are currently taking in the spaces provided below.

Patient Name: **Date of Birth:** **Date:**

Start Date	Name of Medication	What is this used for?

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Dental History Form

Patient Name:____________________ Date of Birth:_____________

Purpose of initial visit:			
How long since your last visit and cleaning?			
How often are you brushing your teeth?			
How often are you flossing your teeth?			
	Yes	**No**	**Explain**
Are your teeth sensitive to hot/cold/sweets/pressure?			
Do your gums bleed or hurt?			
Have you ever had gum surgery or treatment?			
Have you lost any teeth or have any been removed?			
If so have they been replaced?			
Do you clench or grind your teeth?			
Does your jaw click or pop?			
Have you experienced any pain or soreness in your facial muscles or ear?			
Are you unhappy with the appearance of your teeth?			
Have you had any orthodontic work?			
Are you interested in any orthodontic work?			
Have you had any unpleasant dental experiences or is there anything you dislike?			
Have you ever had any problems or complications with previous dental treatment?			

PLEASE INITIAL TO VERIFY THAT THE ABOVE INFORMATION IS ACCURATE

Initial:________

ORLAND SMILES

Cancellation/No Show Policy

- We set aside time for you to receive the upmost care and attention so if you are unable to keep your scheduled appointment with us, we ask that you give us a one business day notice prior to your scheduled time. If you cancel within **24 hours** you will be charged a fee of **$35.00**.
- We do understand that emergencies happen and the fee will be waived on a case-by-case basis.

Financial Policies

Financial Responsibility:

- **You are responsible for any remaining balance on your account after 60 days. After this time your account will start accruing late fees of $10 every 30 days when statements are sent.**
- There is a $35 charge for all returned checks. This charge is at or below the amount allowed by the Illinois state statute.
- In the event of default: promise to pay interest on the indebtedness, collection costs and related attorney's fees. This will be a minimum of $50 if your account is sent to a collection service.

Dental Insurance:

- Unless prior arrangements are made, you will be expected to pay your portion as services are provided. We provide a treatment plan that will **estimate** your portion due at the time of treatment that takes into account your co-pay percentage.
- Because your insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over a claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits.
- **Any balances not paid by the insurance company within 60 days of submission become the patient's responsibility.**
- For state of Illinois employees, you will pay in full and be reimbursed by your insurance company currently they pay claims at 326 days.

Payment Options:

- We accept cash, check, and major credit cards. **If treatment is started without any financial arrangements, understand that payment is due in full at the time that service is rendered**.
- If you have no insurance we offer a 10% cash and 5% senior discount.

I understand and agree to the financial Cancellation and No Show policies of this office.

______________________________ _______________

Patient Signature Date

Orland Smiles

Acknowledgement of Receipt of Notice of Privacy Practices

The Orland Smiles Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

By signing this form you will be confirming that you have received a copy of the office Notice of Privacy Practices.

____ _______________
Print Name (If child, parent's name) Date

____
Sign Name

If written acknowledgement is not obtained please check the reason:

- ☐ Notice given - Patient unable to sign
- ☐ Notice given – Patient refused to sign
- ☐ Emergency situation
- ☐ Other ____