welcome

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE

REGISTRATION

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. Do you experience dry mouth? ..... YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? ..... YES NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. T150DH

DENTAL HISTORY

PATIENT NUMBER

welcome

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name _____
   Address _____ Tel: ( )
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) .. YES NO
6. Are you allergic to any medications or substances? (please list) ..... YES NO
7. Do you have any other allergies or hives? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? (please circle) ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
21. Do you have any artificial joints/prosthesis? ..... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
23. Have you ever bled excessively after being cut or injured? ..... YES NO
24. Do you have any stomach problems? ..... YES NO
25. Do you have any kidney problems? ..... YES NO
26. Do you have any liver problems? ..... YES NO
27. Are you diabetic? ..... YES NO
28. Do you have fainting or dizzy spells? ..... YES NO
29. Do you have asthma? ..... YES NO
30. Do you have epilepsy or seizure disorders? ..... YES NO
31. Do you or have you had venereal or any sexually transmitted disease? ..... YES NO
32. Have you tested HIV positive? ..... YES NO
33. Do you have AIDS? ..... YES NO
34. Have you had or do you test positive for hepatitis? ..... YES NO
35. Do you or have you had T.B.? ..... YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? ..... YES NO
38. Do you habitually use controlled substances? ..... YES NO
39. Have you had psychiatric treatment? ..... YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there anything else we should know about your health that we have not covered in this form? _____
43. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. T140MH

MEDICAL HISTORY

_____

[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the Individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Form No. T303HA

Welcome to our practice: WAUCONDA DENTAL EXCELLENCE

Your dental care is our major concern. It is our policy to help you plan your treatment to achieve your best dental health.
The following options are provided for your convenience. Please choose the one that best fits your needs.

Emergency Care and First Appointment:
Full payment is required at the time service is rendered (cash or credit card only). If you have insurance coverage, payment for this visit is required, but our office will arrange for your insurance company to sent payment directly to you regarding this treatment.

Insurance Welcomed:
We are happy to help you with your insurance. We process your forms, make inquiries to your insurance company about your coverage and often wait 4-6 weeks after your treatment is completed for the insurance to pay their portion. Please keep in mind we provide there services to help you utilize your insurance benefits. However, your deductible and or Co-Payment of 30% to 50% is due and payable to each visit instead of full payment for services rendered.

Patients Without Insurance:
If you are not covered by insurance, our fees are due and payable at the time services are rendered. We accept cash, check (with proper identification) for the exact amount of treatment and credit cards (Visa, Master Card, Discover and American Express).

Cancelled or Failed Appointments:
There will be a $100.00 cancellation fee for any appointment failed or cancelled without 24 hours prior notice. Each NSF check is subject to a $50.00 service charge.

PLEASE INDICATE HOW YOU WISH TO HANDLE YOUR ACCOUNT.

_____a) PAYMENT AS SERVICE IS RENDERED
(Cash, Check with ID, or Credit Card)

_____b) INSURANCE PAYMENT
(Payment of 30% to 50% is due and payable at each visit payment balance by Cash, Check with ID, or Credit Card)

_____c) CARE CREDIT FINANCING
(Financing monthly payment plans of 6-12 months for treatment over $1,000 dollars)

THERE WILL BE A $50.00 CHARGE FOR ALL NSF CHECKS.

_____	_____	_____
Patient name (please print)	Patient Signature	Date

Informed Consent:
Covid-19

I understand that I am consenting to an elective treatment/procedure/surgery that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has beed declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my treatment/procedure/ surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at the time.

I understand that this elective procedure may put me at increased risk for becoming infected with COVID-19.
By signing this content form I accept that risk and give my permission to proceed with the treatment/procedure/surgery listed below.

I have been given the choice to have my treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of Patient:_____

Patient's or Guardian's Signature: _____

Patient's Date of Birth: _____ Date: _____

Name of Provider: Dr. Rodriguez D.D.S
Treatment/procedure/surgery