2631 Williamsburg Ave., Suite 201
Geneva, Il. 60134
www.genevafamilydental.com

Thank you for visiting Geneva Family Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name_____ Preferred Name _____
LAST FIRST M.I.

Address_____
STREET CITY STATE ZIP

Date of Birth_____ Male_____ Female_____

Email_____ Married_____ Single_____ Other_____

Phone: Home ( )_____ Social Security# _____
Work ( )_____ May we contact you at work? Yes____ No_____
Cell ( )_____ Employer_____ Profession_____

Emergency Contact_____ Phone #_____

Insurance Information

Subscriber Name_____ SS#_____ DOB_____

Employer_____ Ins. Co._____ ID#_____

Ins. Co. #_____Group#_____

Relationship to Patient_____ Married_____ Single_____ Other_____

How were you referred to us? _____

What is the reason for this visit? _____

Date of last dental visit? _____ Last Cleaning?_____ Last X-rays_____

How often do you brush? _____ Floss or Water pik? _____
Have you ever used or currently using fluoride? Yes _____ No _____

Do you have any dental problems now? Yes_____ No_____

If yes describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes___ No___
Sweets? Yes___ No___
Biting or chewing? Yes___ No___
Have you noticed any mouth odors or bad taste? Yes___ No ___
Do you frequently get cold sores, blisters or lesions? Yes___ No ___
Do your gums bleed or hurt? Yes___ No ___

Have you ever had:

Orthodontic treatment? Yes ___ No___
Oral surgery? Yes___ No___
Periodontal treatment? Yes___ No___
Oral Appliances? Yes___ No ___
(Nightguard, snore guard, retainer, Cpap etc.)
A serious injury to mouth or head? Yes___ No ___
If yes, describe_____
Do you get food caught in your teeth? Yes___ No ___

Have you ever experienced?

Clicking or popping of the jaw? Yes___ No ___
Pain (joint, ear, side of face) Yes___ No ___
Difficulty opening of closing the mouth? Yes___ No ___
Difficulty chewing on either side? Yes___ No ___
Headaches, neck aches, or shoulder aches? Yes___ No ___
Anything you want to change about Your smile? Yes___ No ___
Would you like to discuss whitening? Yes___ No ___
Do feel nervous at the dentist? Yes___ No ___
What is your concern? _____
Have you ever had a bad dental experience? Yes___ No ___
If yes, explain _____

Do you:

Clench or grind while awake or asleep? Yes___ No ___
Bite your cheeks or lips? Yes___ No ___
Mouth breathe while awake or asleep? Yes___ No ___
Snore or other sleep disorders? Yes___ No ___
Do you feel tired after full night sleep? Yes___ No___
Smoke or use tobacco products? Yes___ No ___

Is there anything you want to change about your smile? Yes___ No ___

Explain:

Medical History

1. Physicians Name _____ Phone ( ) _____
   Have you had any medical care in the past two years? Yes___ No ___
   Describe_____
2. Have you taken any medications or drugs in the past two years? Yes___ No ___
3. Are you currently taking any medication, drugs, pills, or herbal remedies?
   including aspirin? Yes___ No ___
   *If YES please list all medications or give us a list.
   Medications or Supplements

4. Have you ever taken prescription weight loss pills? Yes___ No ___
5. Are you aware of any allergies to medications? Yes___ No ___
   Explain _____

Indicate which of the following you have had or presently have:

_*Autoimmune Disease	**_*Cancer**	**_*Heart Surgery**	**_*Pre-medicate**
_Abnormal Bleeding	**_ADHD**	**_Allergies**	**_Allergy Amoxicillin**
_Allergy Aspirin	**_Allergy Ceftin**	**_Allergy Codeine**	**_Allergy Erythromycin**
_Allergy Latex	**_Allergy Penicillin**	**_Allergy Sulfa**	**_Allery Tetracycline**
_Anemia	**_Anorexia**	**_Anxiety**	**_Arthritis**
_Artificial Heart Valve	**_Asthma**	**_Autism**	**_Blood Disease**
_Blood Transfusion	**_Bulimia**	**_Celiac**	**_Cephalexin Allergy**
_Chemotherapy	**_Colitis**	**_Cong. Heart Disease**	**_Crohn's Disease**
_Diabetes 1	**_Diabetes 2**	**_Difficulty Breathing**	**_Dizziness**
_Drug Abuse	**_Dye Allergies**	**_Egg Allergy**	**_Emphysema**
_Epilepsy	**_EPI-pen**	**_Excessive Bleeding**	**_Facial Surgery**
_Fainting	**_Fever Blisters**	**_Frequent Headaches**	**_Glaucoma**
_Gluten Allergy	**_Growths/Tumors**	**_Hay Fever**	**_Head Injuries**
_Heart Attack	**_Heart Disease**	**_Heart Murmur**	**_Hemophilia**
_Hepatitis A, B, or C	**_High Blood Pressure**	**_High Cholesterol**	**_HIV/AIDS**
_HPV	**_HPV Immunization**	**_Idiopathic Anaphylaxis**	**_Jaundice**
_Joint Replacement	**_Kidney Disease**	**_Liver Disease**	**_Low Blood Pressure**
_Milk Allergy	**_Mitral Valve Pro.**	**_Nut Allergy**	**_Tree Nut Allergy**
_Pacemaker	**_Parkinson's Disease**	**_Pre-Cancer Cells**	**_Psychiatric Disease**
_Radiation Treatment	**_Respiratory Problems**	**_Rheumatic Fever**	**_Rheumatism**
_Seasonal Allergies	**_Seizures**	**_Sensory Problems**	**_Shingles**
_Sickle Cell Anemia	**_Sinus Problems**	**_Spectrum Disorder**	**_STD**
_Stomach Problems	**_Stroke**	**_Thyroid Problem**	**_Tuberculosis**
_Ulcers	**_Venereal Disease**	**_Vertigo**	**_Other**

-Women	**_Pregnant**	**_Nursing**	**_Birth Control**

Treatment Authorization
I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements, regarding my medical condition. I will notify the doctors at my next visit if I have any changes in my health. Payment for all treatment and services are my responsibility.

Patient Signature_____ Date_____
Parent/Guardian Signature_____ Date_____

Geneva Family Dental

Acknowledgement of receipt of Privacy Practices
You may refuse to sign the acknowledgement

If you would like a copy of our privacy practices, please ask the front desk

I _____ have received a copy of the office's Notice of Privacy Practices.
Signature: _____
Date: _____
For office use only

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

*Individual refusal to sign
*Communication barriers prohibited obtaining the acknowledgement
*Other (please specify)
_____

Staff Initials _____

Geneva Family Dental Financial Agreement

Thank you for choosing us to provide your family's dental care! We consider it and honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. The Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business staff.

DENTAL INSURANCE:

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to do the following:

-You must provide us with your insurance card and all the information necessary to verify your coverage to file your claim.

-Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.

-Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

PAYMENT POLICY:

-We accept cash, personal checks, debit cards, Visa, MC, Discover, Amex, and Care credit.

-After your dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

-If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due.

-We do not file claims for medical insurance.

PATIENTS WITHOUT INSURANCE COVERAGE:

We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS:

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for full payment with no exception. This office will attempt to collect payment from a parent that is not present in the office at the visit.

RETURNED CHECKS:

A $35 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES:

Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% of the unpaid balance will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account. An account with an unpaid balance past 90 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: and interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

FEE FOR MISSED APPOINTMENT IF 48 HOUR NOTICE IS NOT GIVEN: Initial_____

To reschedule or cancel an appointment, you must notify us at least 48 hours in advance to avoid a missed appointment fee of up to $100. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

RECORDS AND REIMBURSEMENT:

Original records including radiographs are the property of this office. If you desire, we will provide you with a copy.

CONSENT AND AUTHORIZATION:

I authorize dental treatment on MYSELF or my CHILD and agree to pay all related professional fees. Fees not covered by dental insurance will be promptly paid upon notification of this office. I have read and understand this document in its entirety, outlining office policies and financial polices of Geneva Family Dental. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name_____Signature_____Date _____