Date ______________________

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	Drivers License and State

Primary Insurance Company ______________________ Group ______________ Subscriber ______________

Secondary Insurance Company ______________________ Group ______________ Subscriber ______________

Responsible Party

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? ______________________

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon

❑ Other______________ ❑ TV/Radio Ad ❑ Newspaper Ad ❑ Direct Mailing ❑ Sign by Building

If you were referred, whom may we thank for referring you? ______________________

CONSENT

•I will answer all health questions to the best of my knowledge __________
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature   Date   Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed____**Date**__________________

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)__________

Previous Dentist__________ Last Visit__________ Date of last cleaning__________

Reasons for changing dentists:__________

What problems have you had with past dental treatment?__________

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:__________

How often do you brush?__________ Do you floss? ❑ Yes ❑ No How often?__________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?__________
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? *please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3 .Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?______ How many years?______
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year______Type of operation:__________Year______Type of operation:__________
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____.
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction

Doctor Notes Only:

36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

21. Y N Do you have any other medical problem or medical history NOT listed on this form?__________

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?__________

Please list all medications you are currently taking:

Medicine__________Condition__________
Medicine__________Condition__________
Medicine__________Condition__________
Medicine__________Condition__________
Physician's Name__________Phone__________
Address__________ Fax __________

In the event of an emergency please contact:

Name__________Relationship__________Phone __________
Name__________Relationship__________Phone __________

Initial medical/dental health reviewed by:

X__________ / ____/____ X__________ / ____/____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X__________ / ____/____ X__________ / ____/____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT HIPAA AUTHORIZATION FORM

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

Parties to whom information may be disclosed

Name ______________________________ Relationship ___________________

Name ______________________________ Relationship ___________________

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer;
- Inspect or copy the protected health information to be used or disclosed;
- Refuse to sign this authorization knowing that you will not condition treatment or payment on my providing this authorization (except for research related treatment).

I understand that information used or disclosed or pursuant to this authorization may be subject to additional disclosure by the recipient and no longer protected by HIPAA.

Print Patient Name: ____

Relationship (if other than patient): ____

Signature: ____

Email Address: ____

Steeple Run Family Dental
2783 Maple Avenue
Lisle, IL 60532

Photo Release/ USE

I _______________hereby **authorize** you to use or disclose the specific information described below, only for

the purposes and parties also described below.

Description of the specific information to be used or disclosed:

*Photographs and/or video of Dental Treatments

Persons/entity requesting the information and authorized to make the requested use or

disclosure:

*** Dr. Inthumathy Sivananthan/ Steeple Run Family Dental**

This information is being requested for the following purpose(s): Patient & Employee

Education, Promotion, Marketing, Print or Ads.

This authorization shall remain in effect from the date signed below until 01/01/2050

I understand that:

*I may inspect or copy the protected health information to be used or disclosed

* Information used or disclosed pursuant to the authorization may be subject to re-disclosure

by the recipient and no longer be protected by HIPAA.

(Patient Name): ____________________________ has my permission to have

his/her dental work and/or photographs posted within our dental practice and/or on

our website, social media accounts, video, or slide shows presentations, print ads

and all other marketing or advertising efforts that promote our dental practice and educational benefits to future patients

_______________________________ __________________

Patient/Guardian/Parent Signature Date

(Over 18years old / patient signature