Align Dentistry

aligndentistry@gmail.com

www.aligndentistry.com

9456 W. Irving Park Rd • Schiller Park, IL 60176

(847)928-1020

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Google ☐ Yelp ☐ Walk-in ☐ Insurance Company ☐ Patient (Name Below) ☐ Other (Name Below)

Please enter information for the person financially responsible for the account

◯ If the Patient is the responsible party, please check here, skip this section and continue to the next section.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic 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.

If you have Secondary Dental Insurance,
please present your insurance card to the front desk at the time of your appointment.

Dental History Information

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is the reason for your visit today?

_____

_____

_____

_____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had or have braces (orthodontic treatment)
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Food gets trapped between any teeth
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Have difficulty chewing
- ☐ Clench or grind your teeth
- ☐ Wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Have been treated for gum disease
- ☐ Have or had gum recession
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Have or had a burning sensation in your mouth
- ☐ Missing teeth
- ☐ Other

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

Payment options:
-Cash, Check, Visa, Mastercard, American Express, or Discover Credit Cards
-Convenient monthly payment options from CareCredit Healthcare Credit Card.

Please Note:

Align Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursment for your treatment.

Align Dentistry charges $40.00 for returned checks, $40.00 for any accounts sent to collections, and 10% late fee for any balances past due. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need. However, if we do not receive payment from insurance within 60 days, you will be responsible for payment of your treatment fees.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Cancellation Policy:
At Align Dentistry we require a 24 hour notice for an appointment cancellation or reschedule. If a patient misses 3 appointments and gives less than 24 hour notice, he or she can only be seen on a walk-in basis or choose to put a credit card on file to give Align Dentistry authorization to charge $50.00 for any future failed, cancelled, or rescheduled appointments with less than 24 hour notice.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for Services and Financial Policy form.**

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Medical History

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MVP
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ See Medication List
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

- ☐ Subject to frequent headaches
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Pregnant or Planning Pregnancy
- ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below. * ◯ Yes ◯ No

Pre-Med:

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. *

◯ Yes ◯ No

Medications:

Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa etc. *

◯ Yes ◯ No

Do you have any allergies (including allergies to medications)? If yes, please explain below * ◯ Yes ◯ No

Allergies:

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: ____/____/_____