Atrium Family Dental

1938 E.Lincoln Hwy | Suite 104 • New Lenox, IL 60451 (815)462-9990

Welcome to Atrium Family Dental

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?

____

In an emergency, who should be notified? Please enter name, phone number and relationship below

____

____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________ **Phone:** __________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ____ ____-___
City State Zip Code

Responsible Party Information

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.

◯ I am financially responsible for this account.

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

Secondary 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 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.

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

____

____

Your Primary Care Physician's name, address, & phone number:

____

____

Please mark any of the following to indicate 'Yes' in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to surgery or illness?
☐ Do you use tobacco (smoking or chewing)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Are you currently taking any prescription or non-prescription medications? If so, please list meds below.
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

Please list any medications you are currently taking below and if any of the previous questions above are marked 'Yes', please explain:

____

____

____

____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? ______________

Please indicate if you have experienced any of the following:

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] allergy
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chrons disease
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Iodine
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Osteoporosis Meds
- [ ] Other
- [ ] Pacemaker
- [ ] PCOS
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Seizure
- [ ] Shellfish
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Do you have any other health issues or allergies?

____

____

What is the reason for your dental visit today?

____

____

When was your last visit to the dentist (if to a different office)?

____

____

What was done on your last dental visit (if to a different office)?

____

____

Prior Dentist's name, address, & phone number:

____

____

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2-6 weekly ○ 1-6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate 'Yes' in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

____

____

____

If you could change anything about your mouth, teeth, or smile, what would it be?

____

____

☐ ***To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

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).

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

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

____

____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Atrium Family Dental Financial Policy

Thank you for giving us the opportunity to help you achieve your dental goals. Our staff will strive to deliver the type of service and atmosphere that you should expect from a superb dental office. We have outlined our financial policy for your benefit and understanding and in an effort to eliminate confusion or misunderstanding. We do our absolute best to help you understand and estimate your insurance benefits. Please note that treatment plans change on occasion during the course of treatment because conditions can worsen or improve and can therefore change your financial responsibility in either direction. Any fee estimates provided for dental care, can only be extended for a period of six months from the date of the patient examination. We are always available to answer your questions and/or assist you in any way we can.

Without Dental Insurance

Fees are due and payable at the time treatment is rendered if you do not have insurance coverage. We accept cash and credit cards (MasterCard, Visa, and Discover).

With Dental Insurance

As a courtesy, our office will verify your insurance with your insurance carrier so long as you provide us with your up-to-date and correct insurance information no less than 2 business days before your dental appointment. Our software system then estimates what your insurance will pay. We will then take the time to file the necessary forms to help you receive full benefits of your coverage. Any balance above and beyond the estimate provided that is not paid by the insurance company, including fees that are paid directly to you by your insurance company, will need to be paid at the time service is rendered. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract. Due to thousands of insurance plans, we ask that you know your benefits for it would be impossible for us to know them all. Each insurance plan is unique in what services they will allow. Insurance is an agreement between you and your carrier. If we do not receive your insurance information from you in the time frame stated above, we cannot guarantee that we will be able to process your claim and you will then be responsible for your balance at the time of service. We will then provide you with the necessary information to submit to your insurance for any possible reimbursement.

Financing Available

If you are in need of extensive treatment and/or aren't currently covered by a dental insurance plan, our office offers flexible payment options to make the overall cost of care more manageable. Please ask for more information. All emergency dental services, or any dental services performed without previous financial agreements, must be paid for in cash or by credit card at the time services are performed unless other arrangements are made.

Payment as Services are Rendered:

Your copay is due at the time services are rendered. Because your insurance company makes no guarantee of payment, we cannot always guarantee your exact insurance coverage. Therefore, you may receive a statement with an additional balance after your insurance has met their obligation. We ask that your portion be paid at the time of service or within 15 days of receiving such statement.

Outstanding Balances:

Because we do not want to cause any further unnecessary financial burdens to families with balances, it is our policy that any outstanding copays be paid in full. A 30% finance charge will be assessed and appear on your statement once your account is deemed delinquent. Delinquent accounts will be turned over to a collection agency after 90 days, which may adversely affect your credit rating.

Reservations:

Your reservation time has been reserved just for you. If you cannot keep your reservation, we ask that you kindly give us two business days notice so that we will be able to fill your time slot. Otherwise, our office policy is to charge a fee that covers expenses incurred by late cancellations or failed reservations. The fee will be determined based on the type of appointment and amount of time reserved with a dentist. Exceptions are occasionally made, but are less likely the less notice we are given or more often reservations are missed.

My signature acknowledges that:

☐ ***All questions have been answered truthfully and completely,**
I understand the office policy with keeping appointments.
I understand and will comply with the office financial policy.
I give my consent for treatment.

Name of patient, parent, or guardian completing this form:

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____

____

Response Date: __________