Thank you for choosing Total Dental as your dental care provider. Please take a moment and let us know more about why you chose our practice. This allows us to advertise most effectively and/or thank those that refer us.

PLEASE CHECK HOW YOU INITIALLY HEARD ABOUT OUR OFFICE:

MEDIA:

WEEK - TV __________ WHOI – TV _________ Cable – TV _______ Radio __________

Yellow Pages __________ Newspaper __________ Internet _________ Pandora ________

WCIC Radio __________ Church Bulletin __________

WORD OF MOUTH:

Insurance __________ Doctor __________ Friend __________

Sign __________ Total Dental Care Staff Member – Name: _________________________

Whom may we thank for your referral (if applicable)?

Name:

Phone:

Company:

Email:

TOTAL DENTAL CARE, LTD.

Patient Questionnaire

PATIENT INFORMATION

Name of Minor Child (Last, First, Middle) ____________________

Preferred to be called/Nickname____________________ Sex: ☐ MALE: ☐FEMALE

School and Grade:____________________Date of Birth____________________Age:__________

Home Address____________________City__________State_____Zip Code __________

Patient's E-mail____________________ Home Phone ____________________

FAMILY INFORMATION

Father's Name:____________________Mother's Name:____________________

Father's Date of Birth: ____________________ Mother's Date of Birth: ____________________

Home Address (if different than patient):__________ Home Address: (if different than patient):__________

____________________ ____________________

Father's Employer: ____________________ Mother's Employer: ____________________

Father's Work Phone: ____________________ Mother's Work Phone: ____________________

Email Address: ____________________ Email Address: ____________________

Other family members treated here: ____________________

RESPONSIBLE PARTY /INSURANCE INFORMATION

Insured's Name____________________ Relationship____________________

Insurance Claim's Address____________________City__________State____Zip Code ______

Insured's Social Security Number____________________Insured's Date of Birth__________Phone:______

Insured's Employer____________________Occupation__________Business Phone __________

Responsible Party's Social Security Number ____________________ Relationship ____________________

To the best of my knowledge, the foregoing questions have been accurately answered.

Signature of Parent or Guardian____________________ Date____________________

TOTAL DENTAL CARE, LTD.

Dental/Allergy History

Patient's Name____________________ Date of Birth____________________

Date of patient's last dental visit? ____________________

When was the last time your child had complete dental x-rays taken? ____________________

Name of previous dentist? ____________________

Child's Physician______________ Phone Number: ______________ Date of Last Visit: ______________

Emergency Contact: ______________ Phone Number: ______________ Relationship: ______________

DOES YOUR CHILD HAVE ANY OF THESE ALLERGIES:

☐Yes ☐No **Asprin**

☐Yes ☐No **Codeine**

☐Yes ☐No **Dental Anesthetics**

☐Yes ☐No **Erythromycin**

☐Yes ☐No **Latex or Rubber products**

☐Yes ☐No **Metal of any kind**

☐Yes ☐No **Penicillin**

☐Yes ☐No **Tetracycline**

Any other allergies not listed above? ____________________

HAS YOUR CHILD HAD ANY OF THESE DENTAL RELATED PROBLEMS:

☐Yes ☐No **Clenching/Grinding Teeth**

☐Yes ☐No **Lip Sucking/Biting**

☐Yes ☐No **Speech Problems**

☐Yes ☐No **Thumb/Finger Sucking**

☐Yes ☐No **Mouth Breather**

☐Yes ☐No **Nail Biting**

☐Yes ☐No **Tongue Thrust**

Has your child had any injuries to the face, mouth or chin?____________________

Has your child had any pain/tenderness in his/her jaw joints? ____________________

Does your child brush his/her teeth daily? ____________________

Does your child floss his/her teeth daily? ____________________

Does your child play any musical instruments that involve the mouth? ____________________

Does your child have any handicaps/disabilities? ____________________

TOTAL DENTAL CARE, LTD.

Health History

☐Yes ☐No **Abnormal Bleeding**
☐Yes ☐No **ADD/ADHD**
☐Yes ☐No **HIV Positive (AIDS)**
☐Yes ☐No **Anemia/Radiation Treatment**
☐Yes ☐No **Artificial Bones/Joints/Valves**
☐Yes ☐No **Arthritis**
☐Yes ☐No **Asthma**
☐Yes ☐No **Cancer/Leukemia**
☐Yes ☐No **Cerebral Palsy**
☐Yes ☐No **Congenital Heart Defects**
☐Yes ☐No **Diabetes**
☐Yes ☐No **Fever Blisters**
☐Yes ☐No **Hearing Impairment**
☐Yes ☐No **Heart Attack/Problems**
☐Yes ☐No **Heart Disease**
☐Yes ☐No **Hemophilia**
☐Yes ☐No **Hay Fever**
☐Yes ☐No **Blood Transfusion**
☐Yes ☐No **Congenital Heart Lesions**
☐Yes ☐No **Heart Attack/Disease**
☐Yes ☐No **Hepatitis A B C**
☐Yes ☐No **High/Low Blood Pressure**
☐Yes ☐No **Kidney/Liver Problems**
☐Yes ☐No **Measles/Mumps**
☐Yes ☐No **Mitral Valve Prolapse**
☐Yes ☐No **Mononucleosis**
☐Yes ☐No **Psychiatric Problems**
☐Yes ☐No **Rheumatic/Scarlet Fever**
☐Yes ☐No **Sinus Problems**
☐Yes ☐No **Thyroid Disease**
☐Yes ☐No **Tuberculosis (TB)**
☐Yes ☐No **Drug/Alcohol Abuse**

Does your child have any other disease, condition or problem not listed above that you think the doctor should know about? ☐Yes ☐No If yes, what ____

Please list any and all current medications being used by your child and the reason for each: ________________

____

____

FOR ALL PATIENTS:

I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible for my child. I have had the opportunity to discuss my child's Health History with my doctor. I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all the services rendered by this office.

____

Parent or Guardian Signature | Relationship | Date

TOTAL DENTAL CARE, LTD.

Authorization to Discuss Protected Health Information (PHI)

Please list *any* individuals which you give permission for us to discuss your child's personal information with other than yourself. Our staff is unable to discuss your child's personal information with any individuals *NOT* listed other than yourself, your insurance providers, and other healthcare professionals.

I, ____, authorize the staff of TOTAL DENTAL CARE, LTD. to discuss my child's PHI with the following individuals:

____

____

____

____

The Notice of Privacy Practices

______, YES, I wish to receive a copy of *The Notices of Privacy Practices*

______, NO, I do not wish to receive a copy of *The Notices of Privacy Practices*

____
Parent or Guardian's Name (Printed)

____ ______________________
Parent or Guardian's Signature Date

TOTAL DENTAL CARE, LTD.

FINANCIAL RESPONSIBILITY ASSIGNMENT AND RELEASE

To the extent not paid by the patient's insurer or other party payor(s) within 30 days from the date of first billing, the undersigned agrees, whether he or she signs as agent or patient, that in consideration of the good to be provided and the services to be rendered to the patient, he or she individually obligates himself or herself to pay upon demand, unless other arrangements are approved in writing by Total Dental Care, Ltd. ("Dentist"), the full outstanding balance for the Dentist's actual charges for goods and services provided to the patient at the rates or for such fee(s) as are customary for Dentist. The Patient and/or the undersigned agrees that in the event an employee of Dentist, on his or her own initiative or at the request of the Patient and/or undersigned undertakes to determine the availability of insurance coverage directly or on behalf of the Patient or the undersigned, it shall not be a defense to Patient's and/or the undersigned's financial obligation hereunder that an employee of Dentist re-communicated to Patient and/or the undersigned information received from the Patient's medical insurance carrier to the effect that a procedure or course of treatment was or will be covered under the Patient's policy, notwithstanding that the insurance carrier subsequently denies partial or full payment for such procedure or course of treatment. It is hereby expressly understood and acknowledged by Patient and/or the undersigned that Patient and/or the undersigned are primarily responsible for determining and confirming insurance coverage prior to seeking services.

Beginning on the 30th day from the date service was rendered; all delinquent accounts shall bear interest at the legal rate of eighteen percent (18%) per annum. Should the Account be referred to an attorney or collection agency for collection, the undersigned shall pay all costs of collection, including reasonable attorney fees, collection expenses, costs and court costs which are incurred by the Dentist in enforcing payment after default. There will be a $30.00 charge on all returned checks. It is further hereby agreed that this agreement constitutes the entire agreement of the parties and supersedes and nullifies any prior negotiations, agreements, stipulations or representations unless formalized in writing and directly referencing this agreement. No agent or representative of either party has authority to make, nor is either party relying upon any representation not expressly contained in this Agreement. This Agreement may be amended **only** by an agreement in writing signed by authorized representatives of both parties. It is also agreed that once a suit is filed as a consequence of the undersigned's default with respect to any term or condition of this Agreement, only the Dentist's designated attorney shall have authority to negotiate, compromise or settle any claim arising from such default and that the acceptance of payment by Dentist shall not constitute a waiver of full payment for the amount prayed for by such lawsuit. The undersigned, whether he or she signs as agent or as patient, further authorizes and irrevocably assigns direct payment to Dentist, any insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. The undersigned understands that he or she is responsible for the entire balance on the account notwithstanding the insurance payments which may have been received for services provided. The undersigned hereby consents for a period not exceeding one year to allow Dentist to release patient's financial and medical record and/or copies of pertinent medical record information to Dentist's affiliates and insurance companies or other third party payors. Of course, the above-stated release may be revoked at anytime by Patient, in writing.

NOTICE TO THE UNDERSIGNED: Do not sign this Assignment and Release before you read it and understand it.

____________________________________ ______________________________
SIGNATURE DATE

____

PRINT NAME

TOTAL DENTAL CARE, LTD.

TO THE PARENTS OR LEGAL GUARDIANS OF MINOR CHILDREN:
AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

Illinois law generally provides that only the parent or guardian of a minor child under the age of 18 may consent to dental treatment for that minor. Unless provided for in the Consent by Minors to Medical Procedures Act, it is the policy of TOTAL DENTAL CARE, LTD., not to treat minor children unless they are accompanied by a parent or guardian.

If, at any time in the future, you think you will be sending your minor child to TOTAL DENTAL CARE, LTD., for dental work without being accompanied by a parent or guardian, we need the following authorization to treat the minor child.

I, ____, of ___________________________________, County, State of Illinois, am the Parent or Guardian of ____, a minor child, age _____, born on ____, I hereby authorize my child's dentist or any dentist of TOTAL DENTAL CARE, LTD., to treat said minor child even though I will not be present during the minor child's visit with the provider. Furthermore, I authorize the above-mentioned provider to perform any acts that may be necessary or proper to provide for the dental care of the minor child, including but not limited to the power to authorize any dental care, x-rays, examination, treatment and/or injections or nitrous oxide.

This consent shall be effective from the date it is executed until the day I terminate it, in writing. By signing here, I indicate that (1) I have the understanding and capacity to recognize the importance of, to communicate and to assign the dental care decisions covered by this document, (2) I am fully informed as to the contents of this document, and (3) I understand the full scope and importance of this grant of powers to the agent named herein.

____

Parent or Guardian's Signature | Relationship | Date