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 ANY BOX THAT APPLIES:

MEDIA:

Television_____ Radio_____ Yellow Pages_____

Newspaper_____ Internet_____ Mailer/Flyer _____

Did you happen to see our Billboard?_____

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

Patient Name (Last, First, Middle) _____

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

Social Security Number_____Date of Birth_____Age:_____

Driver's License/State Id No.:_____ Issuing State _____

Home Address_____City_____State____Zip Code _____

E-mail_____ ☐ Yes, send emails for appointment verifications and special offers ☐ No, thanks

Home Phone _____Work Phone_____Cell Phone_____

EMERGENCY CONTACT _____

It is OK to contact me by (Circle all that apply): HOME PHONE/WORK PHONE/CELL PHONE/MAIL/E-MAIL

Marital Status (Circle One) SINGLE/MARRIED/DIVORCED/WIDOWED

Employment Status (Circle One) FULL-TIME/PART-TIME/FT STUDENT/PT STUDENT/RETIRED

EMPLOYMENT/INSURANCE INFORMATION

Employer _____INSURED NAME IN FULL_____

Group Number _____INSURANCE COMPANY _____

SECONDARY INSURANCE INFORMATION

Employer _____INSURED NAME IN FULL_____

Group Number _____INSURANCE COMPANY _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN PATIENT INFORMATION)

Name_____ Relationship_____

Home Address_____City_____State____Zip Code _____

Social Security Number_____Date of Birth_____Phone:_____

Employer_____Occupation_____Business Phone _____

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

Patient Signature(or Responsible Party, if minor)_____ Date_____

TOTAL DENTAL CARE, LTD.

Health History

Patient's Name_____Date of Birth_____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____

Name of previous dentist? _____

How much have you neglected your dental treatment because of fear? _____

How do you feel about getting and maintaining a healthy mouth? _____

How do you feel about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

Name of Family Physician_____Specialist_____

DO YOU HAVE OR HAVE YOU EVER HAD:

☐Yes ☐No **Allergies or Hives**	☐Yes ☐No **Epilepsy/Seizures**	☐Yes ☐No **Mitral Valve Prolapse**
☐Yes ☐No **Anemia**	☐Yes ☐No **Fainting/Dizzy Spells**	☐Yes ☐No **Nervousness**
☐Yes ☐No **Arthritis**	☐Yes ☐No **Genital Herpes**	☐Yes ☐No **Pain In Jaw Joints**
☐Yes ☐No **Angina Pectoris (Chest pain)**	☐Yes ☐No **Glaucoma**	☐Yes ☐No **Psychiatric Treatment**
☐Yes ☐No **Artificial Heart Valve**	☐Yes ☐No **Hay Fever**	☐Yes ☐No **Rheumatic Fever**
☐Yes ☐No **Artificial Joint**	☐Yes ☐No **Heart Disease or Attack**	☐Yes ☐No **Rheumatism**
☐Yes ☐No **Asthma**	☐Yes ☐No **Heart Failure**	☐Yes ☐No **Scarlet Fever**
☐Yes ☐No **Blood Transfusion**	☐Yes ☐No **Heart Murmur**	☐Yes ☐No **Shortness Of Breath**
☐Yes ☐No **Bruise Easily**	☐Yes ☐No **Heart Pacemaker**	☐Yes ☐No **Sickle Cell Disease**
☐Yes ☐No **Chemotherapy(Cancer,ect..)**	☐Yes ☐No **Heart Disease**	☐Yes ☐No **Sinus Trouble**
☐Yes ☐No **Chronic Cough**	☐Yes ☐No **Hemophilia**	☐Yes ☐No **Stroke**
☐Yes ☐No **Cold Sores and Fever Blisters**	☐Yes ☐No **Hepatitis A (infectious)**	☐Yes ☐No **Taken Phen-Fen or Similar**
☐Yes ☐No **Congenital Heart Lesions**	☐Yes ☐No **Hepatitis B (serum)**	☐Yes ☐No **Thyroid Disease**
☐Yes ☐No **Cortisone Medication**	☐Yes ☐No **High Blood Pressure**	☐Yes ☐No **Tuberculosis (TB)**
☐Yes ☐No **Cosmetic Surgery**	☐Yes ☐No **HIV Positive (AIDS)**	☐Yes ☐No **Ulcers**
☐Yes ☐No **Diabetes**	☐Yes ☐No **Joint Replacement**	☐Yes ☐No **Venereal Disease (syphillis,ect)**
☐Yes ☐No **Drug Addiction**	☐Yes ☐No **Kidney Trouble**	☐Yes ☐No **X-ray or Cobalt Treatment**
☐Yes ☐No **Emphysema**	☐Yes ☐No **Liver Disease**	☐Yes ☐No **Yellow Jaundice**

TOTAL DENTAL CARE, LTD.

Do you 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 medications taken, including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

ARE YOU ALLERGIC OR HAVE YOU HAD AN ADVERSE REACTION TO:

☐Yes ☐No **Local Anesthesia (Novocain, etc..)** ☐Yes ☐No **Penicillin or other antibiotics** ☐Yes ☐No **Aspirin or Ibuprofen**

☐Yes ☐No **Codeine or other pain killers** ☐Yes ☐No **Latex or Rubber products** ☐Yes ☐No **Metal of any kind**

Any allergies not listed above:_____

Have you ever had any excessive bleeding requiring special treatment? ☐Yes ☐No If yes, for what reason?_____

Do you use or have you ever used recreational drugs? ☐Yes ☐No Do you smoke? ☐Yes ☐No

Do you drink alcoholic beverages? ☐Yes ☐No If so, how often_____

Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ☐Yes ☐No

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired? ☐Yes ☐No

Do your ankles swell during the day? ☐Yes ☐No Have you lost/gained more than 10 lbs. in last year? ☐Yes ☐No

Do you use more than two pillows to sleep? ☐Yes ☐No Do you ever wake up from sleep short of breath ☐Yes ☐No

Has your medical doctor ever said you have a cancer or tumor? ☐Yes ☐No

Have you had any serious problems associated with any previous dental treatment? ☐Yes ☐No

WOMEN – Are you pregnant or nursing or is there ***any chance*** you might be pregnant? ☐Yes ☐No ***If you are using oral contraceptives,*** it is important you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

FOR ALL PATIENTS: ***I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. I have had the opportunity to discuss my 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.***

_____

Patient Signature (or Responsible Party, if minor) 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 personal information with other than yourself. Our staff is unable to discuss your 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 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*

_____

Patient Signature

_____ _____

Patient Signature (or Responsible Party, if minor) 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.

SEDATION

FOR PATIENTS INTERESTED IN SEDATION:

Total Dental Care, Ltd. offers patients the alternative of Sedation Dentistry, for patients with dental anxiety, time constraints, or just wanting to rest through their procedures. So that we may better understand you, please check all the items below that would apply:

_____ I have had a bad experience(s) at the dentist in the past

_____ I have pain when dental work is done

_____ I hate the needle and/or shots

_____ I cannot get numb even when I do get a local anesthetic

_____ I cannot stand to have dental tools in my mouth

_____ I hate the sound of the drill

_____ I do not like the smell

_____ I gag when dental tools are in my mouth

_____ In the past, I have avoided going to the dentist and only went when I could no longer stand the pain

_____ I have cancelled dental appointments or just not shown up due to fear/anxiety

_____ Time is an issue – it is difficult for me to return for multiple appointments

Please write down anything we have not included that would explain why you are interested in sedation dentistry:

_____

_____

_____

_____

_____

_____

Patient Signature (or Responsible Party, if minor) Relationship

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