ESHA DENTAL

PATIENT INFORMATION

Name________________________________ Date of Birth _____________ Phone # _____________________________

Address ______________________________________ City ___________________State_________ Zip Code ___________

Sex: ☐ M ☐ F Age _______ E-mail____

Is patient a minor: ☐Yes Legal Guardian: ________________________/_________________ Date of Birth____________
Name of legal guardian / Relationship to patient

In case of an emergency? _____________________________/__________________ Phone #______________________
Name of person we need to contact / Relationship to patient

MEDICAL HISTORY

Physician's name _____________________________ Date of last Doctor Visit _________________________________

1. Are you under a physician's care?------------------ ☐Yes ☐ No
2. Have you ever had an adverse reaction --------- ☐Yes ☐ No
   to any dental treatment or medication?
3. Are you taking any medications?------------------ ☐Yes ☐ No
   Please list_____________________
   ____
   ____
4. Do you Smoke?-- ☐Yes ☐ No
5. Do you use alcohol?------------------------------------ ☐Yes ☐ No
6. Do you use drugs or any medication not
   prescribed by a physician?------------------------- ☐Yes ☐ No

8. Have you ever had adverse reaction to?
   - Local anesthetic ☐Yes ☐ No
   - Penicillin or other Antibiotic ☐Yes ☐ No
   - Sulfa Drugs ☐Yes ☐ No
   - Barbiturates (Sleeping pills) ☐Yes ☐ No
   - Iron ☐Yes ☐ No
   - Aspirin ☐Yes ☐ No
   - Other ☐Yes ☐ No

7. (Women only) Are you:
   - Pregnant? ☐Yes ☐ No
   - Breast feeding? ☐Yes ☐ No
   - Taking birth control pills? ☐Yes ☐ No

Check all that apply:

☐Aids
☐Anemia
☐Arthritis, Rheumatism
☐Artificial Heart Valves
☐Artificial Joints
☐Asthma
☐Back Problems
☐Abnormal Bleeding
☐Blood Disease
☐Cancer
☐Chemical Dependency
☐Chemotherapy
☐Chronic fatigue syndrome
☐Circulatory Problems
☐Congenital Heart Lesions
☐Cortisone Treatments
☐Cough – persistent orbloody
☐Diabetes
☐Emphysemas
☐Epilepsy
☐Fainting or Dizziness
☐Glaucoma
☐Headaches
☐Heart Murmur
☐Heart Problems
☐Hepatitis
☐Herpes
☐High/Low blood pressure
☐HIV
☐Jaundice
☐Jaw pain
☐Sensitive to Latex
☐Kidney Disease
☐Liver Disease
☐Mitral Valve prolapse
☐Nervous Problems
☐Pacemaker
☐Psychiatric Treatment
☐Radiation Treatment
☐Respiratory Disease
☐Rheumatic Fever
☐Scarlet Fever
☐Shortness of Air
☐SinusTrouble
☐Skin Rash
☐Stroke
☐Swelling of Feet/Ankles
☐Swollen Neck Glands
☐Thyroidproblems
☐Tonsillitis
☐Tuberculosis
☐Tumor orGrowth
☐Ulcer
☐VenerialDisease

Is there anything we should know regarding your Medical History? ________________________________

CERTIFICATION

To the best of my knowledge, the information that I have provided on these forms are complete and correct. I understand that it is my responsibility to let the Doctor know if there is a change in my health history or in the health history of my child.

Initials: ___________

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made, I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges

Initials: ___________

MINOR/CHILD CONSENT

I am the guardian, mother or father of ____

and there are no court orders now in effect that would prohibit me from signing this consent form. I hereby ask and authorize the dental staff to provide the necessary services for the child named above, which may include but are not limited to radiographs and the administration of local anesthetic for treatment that the Dentist has deemed necessary.
Initials: ___________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have dental coverage with____ and assign directly to Esha Dental LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions.

The above-named provider may use my minor/child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Initials: ____________

____ ____________________

Signature (Guardian or Parent if Minor) Date

____ ____________________

Please print name (Guardian or Parent if Minor) Relationship to patient

ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal health care operations such as quality assessments and physician's certification.
4. Electronic communication with insurance companies and other health care providers may take place if needed

I have received, read and understood the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at 1409 W Lake St, Addison IL 60101 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restriction, but if agreed then the office is bound to abide by such restrictions.

Patient Name ____ Date of Birth _________________________

Legal Guardian Signature ____ Date _________________________

REQUEST FOR CONFIDENTIAL COMMUNICATION

Written Communication:

☐ I request that all written communication be sent to the address on my registration form.

☐ I request that all written communication be sent to the following address:

Attn: _________________________________ Address_________________________________

____

Oral Communications:

☐ I request to be contacted at the phone numbers that I have provided on my registration form

☐ I request to be contacted only at _______________________________

☐ I request that my dental health and treatment ONLY be discussed with me.

☐ I give Esha Dental LLC permission to discuss my dental health and treatment with the following person(s):

____

Patient Name ____ Date of Birth _________________________

Legal Guardian Signature ____ Date _________________________