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

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ☐ Yes ☐ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	☐	☐
6.	Has the child ever been hospitalized?	☐	☐
7.	Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
8.	Has the child ever received a general anesthetic?	☐	☐
9.	Does the child have any inherited problems?	☐	☐
10.	Does the child have any speech difficulties?	☐	☐
11.	Has the child ever had a blood transfusion?	☐	☐
12.	Is the child physically, mentally, or emotionally impaired?	☐	☐
13.	Does the child experience excessive bleeding when cut?	☐	☐
14.	Is the child currently being treated for any illnesses?	☐	☐
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	☐	☐
16.	Has the child had any problem with dental treatment in the past?	☐	☐
17.	Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
19.	Has the child had any problems with the eruption or shedding of teeth?	☐	☐
20.	Has the child had any orthodontic treatment?	☐	☐
21.	**What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22.	**Does the child take fluoride supplements?**	☐	☐
23.	**Is fluoride toothpaste used?**	☐	☐
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	☐	☐
25.	Does the child suck his/her thumb, fingers or pacifier?	☐	☐
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____Date _____

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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

ESHA DENTAL

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 _____