Arlington Heights Dental Care

Patient Information

37 W. Golf Road
Arlington Heights, IL 60005
(847) 228 - 6118

Patient Information

Name: _____
Last First M. Initial

Address: _____ **Apt #** _____

City _____ **Zip Code**_____
Social Security #: _____
Birth Date: _____ **Sex:** □ M □ F
Marital Status: □ Married □ Single □ Other: _____
Home Phone #: _____
Cell Phone #: _____
Email Address: _____

Responsible Party
(if same as above, please skip)

Name: _____

Address: _____ **Apt #** _____
City _____ **Zip Code** _____
Social Security #: _____
Birth Date: _____

Employment

Occupation: _____
Employer: _____
Business address: _____
City _____ **Zip Code** _____
Business phone # _____ **ext #** _____

Student Status *(circle)*

Full-time	Part-time
School Name:	

Insurance

Primary Insurance Company: _____
Insurance Co. Phone #: _____
Group #: _____

Name of policy holder:_____
Employer: _____
Insurance ID#: _____
Soc. Sec # of policy holder: _____
Birth Date of policy holder: _____

Secondary Insurance Company: _____
Insurance Co. Phone #: _____
Group #: _____

Name of policy holder: _____
Employer: _____
Insurance ID#: _____
Soc. Sec # of policy holder: _____
Birth Date of policy holder: _____

Getting to know You

How did you hear about us?

___ Friend/Family Name:_____
___Phonebook ___Flyer/Ad ___Insurance
___Other: _____

How would you like us to contact you?
(check all that apply)

___ Cell Phone ___Home Phone ____Email
___ Other:_____

Person to contact in case of Emergency:

Name: _____ Phone #: _____

1. I hereby certify that the above information is accurate and will be relied upon for providing dental services and making payment arrangements. I **understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.**
2. By signing below, I understand that you may verify and exchange information on me and any applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to **Arlington Heights Dental Care Mengyu Tsai, DDS LTD** of insurance benefits otherwise payable to me. **I understand that I am financially responsible for any charges not covered by this authorization.** I authorize release of any information relating to any dental claim or claims.

_____ _____
Signature of Patient or Responsible Party Date

Arlington Heights Dental Care ©
Mengyu Tsai DDS
(847) 228 - 6118

DENTAL HEALTH HISTORY
Confidential

Today's Date:_____

Patient Name _____ Birthdate _____
Last First Initial

DENTAL HISTORY

Reason for today's visit _____ Date of last dental Care _____

Former Dentist_____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- □ Bad Breath
- □ Bleeding Gums
- □ Clicking or Popping Jaw
- □ Food collection between teeth
- □ Grinding Teeth
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sensitivity to cold
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations?_____ If yes, describe _____

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (✓) if you have or have had any of the following

- □ Anemia
- □ Arthritis, Rheumatism
- □Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problems
- □ Hemophilia
- □ Hepatitis
- □ High Blood Pressure
- □ HIV / AIDS
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of feet or ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

MEDICATIONS

List medications you are currently taking _____
_____
_____

Pharmacy Name _____

Phone _____

ALLERGIES

- □ Aspirin
- □ Barbiturates (Sleeping Pills)
- □ Codeine
- □ Local Anesthetic
- □ Penicillin
- □ Sulfa
- □ Latex _____
- □ Other _____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

Arlington Heights Dental Care ©
Mengyu Tsai DDS
(847) 228 - 6118

PRIVACY PRACTICE AGREEMENT

1. CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Signature: X _____

2. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, We will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Parties, including any revisions of our Notice, at any time by contacting:
Arlington Heights Dental Care: (847) 228 – 6118

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Additional Patient Names:

Name 1:_____ Relation:_____

Name 2:_____ Relation:_____

Name 3:_____ Relation:_____

I (we) understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Guarantor Name: _____ Signature: _____ Date:_____

OFFICE POLICY

1. **PATIENTS HAVING DENTAL INSURANCE COVERAGE MUST PAY THEIR UNCOVERED PORTION INCLUDING DEDUCTIBLE AT EACH VISIT.**
   - A charged oral-examination and X-ray photos are routine procedures for all 1st. time visitors.
   - All emergency patients must pay in advance for the 1st. visit.

2. **AUTHORIZATIONS AND RELEASE.**
   - I authorize and request my insurance company to pay directly to the dentist.
   - I understand that this dental office will submit the bill to insurance company on my behalf for courtesy only. My dental insurance carrier may pay less than the actual bill or to deny the whole bill for services for any reason. I agree to be responsible for payment if all services rendered on my behalf or my dependents.
   - If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge will be assessed each month. I realize that failure to keep this account current may result in this OFFICE being unable to provide additional dental service. In case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.
   - I understand and agree with the following charges:

i. Broken appointment charge:	$35/each
ii. Late payment fee:	$30.00/month
iii. Bounce check charge:	$30/each check
iv. Collection fee:	$35% of the outstanding balance

Notes: This office reserves the right to change the above charges without notice.

Signature: X _____

Revised: 1/22/2011