



Kedzie Dental Clinic
Family and Cosmetic Dentistry

PATIENT INFORMATION

Last Name: _____ First Name _____ MI: _____

Address: _____ P.O BOX _____

City: _____ State: _____ ZIP: _____

Home Phone _____ Work Phone: _____ Cell Phone _____

Social Security #: _____ Date Of Birth: _____ Gender _____

Preferred Language _____ Employer _____

Marital Status: Minor () Single () Married () Divorced () Widow () Other () _____

Email Address _____

How did you hear about our office? _____

Responsible Party for Account

Last Name _____ First Name: _____ MI: _____

Relationship to Patient () Self () Spouse () Legal Guardian () Other: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Social Security# _____ Date of Birth: _____

Emergency Contact

Last Name: _____ First Name: _____ MI _____

Relationship to Patient () Self () Spouse () Legal Guardian () Other _____

Home Phone: _____ Work Phone: _____

Insurance Information

Primary Insurance: _____ Policy Number _____

Group Number _____ Address _____

City _____ State _____ Zip Code _____

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Kedzie Dental Clinic

6035 N KEDZIE AVE | CHICAGO IL, 60659 | (773) 274-9514

Written Financial Policy

Thank you for choosing Kedzi Dental Clinic. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover Card
- Convenient Monthly Payment Options¹ from CareCredit Healthcare Credit Card
 - o Allow you to pay over time
 - o No annual fees or pre-payment penalties

Please note:

Kedzie Dental Clinic requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$1000 or more, a \$25.00 deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

A fee of \$25.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

A fee of \$25.00 is charged for a copy of dental x-ray.

Kedzie Dental Clinic charges \$35.00 for returned checks.

We apologize for any inconvenience, but we don't do refunds it will be posted in your account as a credit.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.



HIPPA

PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or use for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

The Consent was signed by:

Printed Name Patient or Representative

Relationship to Patient

Signature _____ Date _____

(If other than patient)

Printed Name. Practice Representative

Signature _____ Date _____