Patient Information

Full Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Mobile #: _____

Email: _____ Employer: _____

Sex: M / F Birth Date: ____ /____ /_____ SS#:_____

Family Status (circle): Single Married Child

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone #: _____

How did you first hear about our office? (circle one):

Facebook/Instagram

Online Search

Insurance Website

Viewed Sign

Another Patient: _____

Responsible Party for Minor

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Mobile #: _____

Email: _____

Birth Date: ____ /____ /_____ SS#:_____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Plan Name: _____ Insurance Phone #: _____

Insurance Address _____City, State, Zip_____

Group #: _____ ID #: _____

[DO YOU HAVE ANY ADDITIONAL INSURANCE? YES ___ / NO ___ *If yes, complete the following.]

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Plan Name: _____ Insurance Phone #: _____

Insurance Address _____City, State, Zip_____

Group #: _____ ID #: _____

Medical History

Who is your Physician? _____ When did you last see them? _____

Are you taking any medications or drugs? Y / N *If yes, for what purpose? _____

Please list all medications or drugs: _____

_____

Are you allergic to any medications? Y / N *Please list them _____

Have you ever had or been treated for the following?

Chest Pains..... Yes☐ No☐

Heart Disease or Heart Lesions..... Yes☐ No☐

Pacemaker..... Yes☐ No☐

Abnormal Blood Pressure..... High☐ Low☐

Epilepsy or Seizures..... Yes☐ No☐

Ulcers..... Yes☐ No☐

Tuberculosis or Lung Disease..... Yes☐ No☐

Diabetes..... Type 1☐ Type 2☐

Bleeding Problems..... Yes☐ No☐

Anemia..... Yes☐ No☐

Kidney Trouble..... Yes☐ No☐

Drug or Alcohol Addiction..... Yes☐ No☐

Do you smoke?..... Yes☐ No☐

Do you chew tobacco?..... Yes☐ No☐

Major Surgery (*Please List*)..... Yes☐ No☐

Cancer or Tumors..... Yes☐ No☐

Radiation☐ Chemotherapy☐

Jaundice or Hepatitis..... Yes☐ No☐

Asthma..... Yes☐ No☐

AIDS or HIV Positive..... Yes☐ No☐

Shortness of Breath..... Yes☐ No☐

Arthritis..... Yes☐ No☐

Stroke..... Yes☐ No☐

Thyroid Disorders..... Yes☐ No☐

Joint Replacements (*List Replacement & Year*) Yes☐ No☐

Other Medical Conditions? (*Please List*) Yes☐ No☐

Are you subject to fainting spells? Yes☐ No☐

Are you on a special diet? Yes☐ No☐

Do you take aspirin frequently? Yes☐ No☐

Ever take a medicine for osteoporosis? Yes☐ No☐

Women:

Do you anticipate becoming pregnant? Yes☐ No☐

Are you or could you be pregnant? Yes☐ No☐

Are you taking birth control pills? Yes☐ No☐

Dental History

Name of previous dentist and location? _____ Date of last dental exam? _____

How often do you brush your teeth? _____ How often do you use dental floss? _____

Are you experiencing pain from your mouth at this time? Yes☐ No☐

Do you have any teeth that are tender to biting or pressure? Yes☐ No☐

Do your gums bleed? Yes☐ No☐

Do you have any teeth sensitive to hot, cold, or sweets? Yes☐ No☐

Have you ever worn braces to straighten your teeth? Yes☐ No☐

Do you clench or grind your jaws while sleeping or during the day? Yes☐ No☐

Do you have any difficulty opening or closing your mouth? Yes☐ No☐

Do your jaws hurt? Pop? Click? Yes☐ No☐

Do you have any concerns when you receive dental care? Yes☐ No☐

Are any of your teeth yellow or stained? Yes☐ No☐

Do you have any crowns or fillings that do not match your teeth? Yes☐ No☐

Would you like your teeth to be whiter? Yes☐ No☐

I understand that providing incorrect information can be dangerous to my health. To the best of my knowledge, the information above is complete and accurate.

Signature _____ Date _____

Permission to use Surveys and Reviews

As a patient of Chatham Dental Center, we greatly value your opinions.
If for any reason you were unhappy with your experience, please contact us.

If you enjoyed your visit, we would appreciate that feedback as well. To give us feedback you can:

- Fill out the survey that we send after your appointment via email.
- Leave us a review on Facebook, Google, Yelp, and/or Yahoo.

This information may be helpful to prospective patients that would love to hear your comments. We would appreciate your permission to share your feedback (reviews and surveys) through our website and print media.

*We will **never** disclose your full name or any personal information about you.*

If you agree to allow us to use your reviews, please sign and date this form. We greatly appreciate your help and, as always, we value your opinions.

I, _____, on (*date*)_____ give my permission for Chatham Dental Center, Ltd. to use my feedback, reviews and surveys on their website and print media. I understand that my full name will not be used and no personal information will be disclosed.

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. We are pleased to accept payments through checks, cash, most debit and credit cards, as well as Care Credit.

Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to **estimate** your coverage, and file your insurance. It is essential that you read and understand your coverage and pay special attention to any requirements.
- Our office policy states that you are responsible for your bill. The **estimated** patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier we will notify you. Failure of your insurance carrier to reimburse our office within 90 days will result in our billing you directly for the remaining balance.
- We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health.
- Chatham Dental Center is happy to accept all insurance companies (as long as you are free to see any dentist you choose) but we are only in-network with with select insurance companies.
- If your dental coverage changes for any reason, please notify the office immediately.

Usual and Customary Fees

Accounts over 90 days are assessed a 24% annual interest charge (2.0% per month) regardless of insurance. *Accounts that are turned over to collections will be charged additional fees.*

I have read the Financial Policy. I understand and agree to this Policy.

Signature _____ Date _____

Patient Consent/Acknowledgment

By signing this form below, you consent to the use and disclosure of your protected health information by Chatham Dental Center, Ltd., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised notice by simply contacting this office at (217) 483- 3545 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures to your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE. ALL FORMS ARE SUBJECT TO CHANGES IN THE FEDERAL LAW AND APPLICABLE STATE LAWS.
SEEK LEGAL ADVICE BEFORE USE.

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORTS TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE RECEIVED, REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Signature _____ Date _____