Robert Q. Marshall, DDS

SMILES Of Orland Park

Thank you for choosing us as your Dental Healthcare Team! Our goal is to provide you with excellent dental care. To help us meet all your dental healthcare needs, please provide us with the following information. If you have any questions or concerns, please talk with one of our team members who will be happy to assist you.

Patient Information (Confidential)

Date_____ Gender: (M/F) SSN_____

Name_____ DOB_____ Home Phone_____

Address_____ City_____ State___ Zip_____

Check appropriate: ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated

Person to contact in case of an emergency_____

Whom may we thank for referring you_____

Email address: _____ Texting: Yes__ No__ Cell Phone_____

Responsible Party

Person Responsible for this account_____ Relationship to patient_____

Address_____ Home Phone_____

Employer_____ Work Phone_____

DOB_____ SSN_____

Insurance Information

Name of Subscriber_____ Relationship to Patient_____

Subscriber's DOB_____ SSN or ID#_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group#_____ Phone_____

Insurance Company_____ Address_____ City_____ State___ Zip_____

Do you Have Additional Insurance? Yes No If yes please complete the following:

Name of Subscriber_____ Relationship to Patient_____

Subscriber's DOB_____ SSN or ID#_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group#_____

Insurance Company Address_____ City_____ State____ Zip_____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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? _____
Have you ever been hospitalized or had a major operation? _____
Have you ever had a serious head or neck injury? _____
Are you taking any medication, pills, or drugs? _____
Do you take, or have you taken Phen-Fen or Redux? _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
_____
Are you on a special diet? _____
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐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

Please check all boxes that apply.

☐Aids/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problems
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores
☐Congenital Heart Disorder
☐Convulsions
☐Yellow Jaundice
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Thirst
☐Fainting/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headache
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pacemaker
☐Heart Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Osteoporosis
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Radiation TX
☐Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growth
☐Ulcers
☐Venereal Disease

Have you ever had any serious illness not listed above? ☐Yes ☐No

Comments: _____

Signature of Patient, Parent or Guardian: _____

SMILE EVALUATION

Patients Name:_____ **Date:**_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES ___NO___
Do you have spaces between your teeth that bother you?	YES___ NO___
Do you have chips or uneven edges on your teeth?	YES___ NO___
Do you feel that your teeth are too long or too short?	YES___ NO___
Do you have dark fillings that show when you smile?	YES___ NO___
Do your gums show too much when you smile?	YES___ NO___
Are your teeth crowded or crooked?	YES___ NO___
Do you have existing crowns or dental work that you consider "ugly"?	YES___ NO___
Are you self conscious of your teeth and/or smile?	YES___ NO___
Has anyone (family member, friend, etc) ever suggested that you Should have something done with your teeth or smile?	YES___ NO___
Do you avoid smiling when you have your picture taken?	YES___ NO___
Would you like to improve your existing smile?	YES___ NO___
Do you wish you had a "new smile"?	YES___ NO___

What concerns do you have regarding dental treatment to improve your smile?

☐ Fear of treatment
☐ Time of treatment concerns
☐ Financial concerns
☐ Distance to office
☐ Not understanding treatment
☐ Embarrassment
☐ Other:
_____

When restorative treatment is completed in our office, we offer a three-year warranty. We will replace or redo your restorative treatment ***providing*** *you come in for your hygiene recall appointment and complete all recommended treatment.*

Our Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality of care. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time of service unless prior financial arrangements are made. Our office accepts cash, personal checks, MasterCard, Visa and Discover in addition to prepayment discounts. Outside financing is available upon request and approval.

NSF Checks: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistant; you will be responsible for any collection and/or legal charges incurred up to 35%.

Interest Charged: An interest charge of 1.5% (18% annual percentage rate) will be applied to all accounts with or without insurance that is not paid in full after 60 days from the time services was rendered.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company the day services are rendered.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Missed Appointments: Once an appointment is made it is reserved specifically for you so we do ask in advance that you please give us the courtesy of at least 48 hours notice for any appointment change requests. We reserve the right to charge a fee of $125.00 to any cancellation or change request that does not fall within that timeframe.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

CONSENT:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

When restorative treatment is completed in our office, we offer a three-year warranty. We will replace or redo your restorative treatment **providing** you come in for your hygiene recall appointments and complete all recommended treatment.

Patient Signature (Parent of Child)_____Date_____

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 certifications.

I have received, read and understand your *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.*

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 operation. I also understand that you are not required to agree to my requested restriction, but if you agree that you are bound to abide by such restriction.

Patient Name (print) _____

Relationship to Patient _____

Signature _____ Date _____

How would you like us to communicate with you?

Patient Name (print) _____ Date of Birth _____

Address _____

If the address provided above is not your home address or if it is not a street address, please provide us with a street address for purposes of ensuring payment and/or written communications.

Home # _____ May we leave a message? Yes _____ No_____

Work# _____ May we leave a message? Yes _____ No_____

Cell # _____ May we leave a message? Yes _____ No_____

Email _____ May we leave a message? Yes _____ No _____

May we send an appointment reminder text message? Yes _____ No _____

May we leave a message that you need pre-medication? Yes _____ No _____

I do not want a reminder left at all _____ (initials) I do not want a postcard sent _____ (initials)

VERBAL AND WRITTEN COMMUNICATION

I _____ give permission of written or verbal communication to _____.

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* but was unable to do so as document below.

Date _____ Reason _____ Initials _____