WILMETTE DENTAL

REGARDLESS OF INSURANCE COVERAGE, PAYMENT IS EXPECTED AT TIME OF SERVICE.

PATIENT INFORMATION

Title_____ First Name_____ Initial_____ Last Name_____

Nickname_____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Social Sec. #_____ How did you hear about our office?_____

Employer_____ Occupation_____

Work Address_____ City_____ State_____ Zip_____

Marital Status (please circle) S M W D Email Address_____

PERSON RESPONSIBLE FOR PAYMENT (if different from above)

Title_____ First Name_____ Initial_____ Last Name_____

Social Sec. #_____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer_____ Occupation_____

Work Address_____ City_____ State_____ Zip_____

DENTAL INSURANCE INFORMATION

Do you have Dental Insurance? Yes No ***Please present your Insurance Card to our Receptionist.***

I acknowledge that I will be personally responsible for any and all charges. I understand that recovery from third party insurances is my responsibility and not the responsibility of the dentist. I agree to pay any amount not paid by my insurance company within thirty (30) days from the date of service.

I further agree to pay a service fee of 5% per month, which will be assessed on any unpaid balance after 30 days.

_____ _____

Signature of Person Responsible for Payment *Date*

Patient's Acknowledgment of Receipt of Notice of Privacy Policy

(You May Refuse to Sign This Acknowledgement)

I have received a copy of the Notice of Privacy Policy for the office of Wilmette Dental, Ltd.

Signature: _____ Date:_____

PATIENT HEALTH QUESTIONAIRRE

Do you have any of the following conditions:

Y	N	Conditions
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defect
☐	☐	Heart Disease Or Angina
☐	☐	Heart Attack
☐	☐	Heart Surgery When was the surgery done?
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Pacemaker
☐	☐	Artificial Joint When was the surgery done?
☐	☐	Organ Transplant When was the surgery done?
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Diabetes
☐	☐	STD (Sexually Transmitted Disease)
☐	☐	Hepatitis, Liver Disease
☐	☐	HIV+ AIDS
☐	☐	Cancer
☐	☐	Chemo Or Radiation Therapy
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Difficulty Breathing
☐	☐	Stroke
☐	☐	Epilepsy / Seizures
☐	☐	Fainting Spells
☐	☐	Glaucoma
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Psychiatric Problems
☐	☐	Arthritis
☐	☐	Sinus Problems
☐	☐	Thyroid Problems
☐	☐	Tuberculosis

Are you allergic to or have you ever reacted adversly to:

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other:

Y	N	
☐	☐	Do you smoke or use tobacco?
☐	☐	(Women) Are you pregnant or nursing?

Do you have any of the following:

Y	N	
☐	☐	Dental pain or discomfort?
☐	☐	Sensitive tooth or teeth?
☐	☐	Sore or tired jaw or neck?
☐	☐	Do you ever grind or clench?
☐	☐	Dry Mouth?
☐	☐	Bad taste or odor in your mouth?
☐	☐	Gums that bleed easily?
☐	☐	Gum Disease?
☐	☐	Have you had braces?
☐	☐	Have you had any gum treatment?
☐	☐	Unhappy with appearance of teeth?
☐	☐	Have you had difficulty with any previous dental treatment?

Please list any MEDICATION you are now taking and the REASON FOR USE:

Is there any *other* disease, condition, or problem that you think our office should know about:

Print Patient's Name: **Signature of Patient or Guardian:** **Date:**

Patient's Date of Birth (MM/DD/YY):_____ **Patient's Email Address:**_____

Wilmette Dental

Dr. Robert Madrigal

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy**. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office a **24 hours notice** in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within that time frame, this is considered a missed appointment. A fee of $50 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. Moreover, there will be a 5% finance charge on all unpaid balances over 30 days.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50 cancellation fee will be applied.

If you have any questions regarding this policy, please let our staff know and we will gladly clarify any questions you may have.

We thank you for your patronage,

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____, (print name), have received a copy of

Wilmette Dental's Appointment Cancellation Policy,

Signature of Patient Date

_____ _____