

5 Dental History

How long ago was your last dental visit? _____

Why have you come in today? _____

Do you have any of the following problems?

Please check	yes	no	Please check	yes	no
Pain with a tooth	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Pain when biting	<input type="checkbox"/>	<input type="checkbox"/>	Unpleasant taste/bad breathe	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to cold	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to hot	<input type="checkbox"/>	<input type="checkbox"/>	Gum problems/Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

6 Medical History

Are you currently under a physician's care? Yes No (circle one)

If yes, for what? _____

Name of Physician _____ Phone _____

Are you taking any medications (prescription or nonprescription)? Yes (Please use chart) No

Name of Medication	Dosage/ Frequency	Reason for Taking

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw Joints* | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Recent Weight Loss | _____ |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Renal Dialysis | _____ |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Rheumatic Fever* | |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatism | |

• Do you use tobacco? Yes No

• Do you use smokeless 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?

- Acrylic Aspirin Codeine Latex Local Anesthetics Metal
 Penicillin Sulfa Other _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian _____

7 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check which option you prefer.

- Cash Personal check Credit Card: Visa MasterCard Discover American Express
- Care Credit- 12 month interest free and low interest payment plans available

8 Financial Policy

Patients are expected to pay by cash, check or credit card the day the service is rendered unless specific arrangements have been made in advance with the financial coordinator.

On all accounts over 90 days, the patient will be responsible for all costs of collection if his or her account is in default, including court costs and reasonable attorney fees.

INSURANCE: Please remember that the patient, not the insurance company, is ultimately responsible for payment of professional services. As a courtesy to you, we will submit to your insurance for your reimbursement. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. Fees charged by our office reflect the high quality of service rendered and will not be adjusted to individual insurance fee structures. The quality of your dental coverage is a direct reflection of the quality of plan selected by your employer. We have no control of individual benefits.

CANCELLATION POLICY: We can only successfully treat you if you keep scheduled appointments. Dr. Noruzi reserves his time for individual patient care. We ask a minimum of **48 hours notice** be given for schedule changes. Patients not showing or canceling at the last minute will be charged **\$50.00 per half hour** of scheduled time wasted, and rescheduling of treatment appointments broken without 24 hour notification will not be made until full payment for the procedure is received.

I certify that I have read and understand the above financial policy:

Date: _____

Signature of patient, parent or guardian

9 Authorization and Release

I authorize Fox River Periodontics, PC 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 payors and/or other health practitioners.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date: _____

Signature of patient, parent or guardian

Consent For Use and Disclosure of Health Information

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out 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 Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Dr. Kamy Noruzi, D.M.D.

Telephone: (630) 232-7400

Fax: (630) 232-7590

Address: Fox River Periodontics, 2075 Blackberry Drive, Geneva, IL. 60134

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 Person 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.

I have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I 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, including disclosures via fax. I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
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