



# Hello!

The magic of a happy, healthy smile is immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

**GRAND DENTAL**  
ASSOCIATES  
**FARNSWORTH**  
DENTAL GROUP  
**CHANNAHON**  
FAMILY DENTISTRY  
**COURTVIEW**  
FAMILY DENTISTRY

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

## about you

How did you hear about us? \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_

Mobile/Cell # \_\_\_\_\_ Pager # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Your Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Birthday \_\_\_\_\_  Male  Female

Marital Status  Single  Married  Divorced  Widowed

## dental insurance

MY DENTAL INSURANCE CO. \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

I have additional coverage through my  Spouse  Parent  Other

Their Name: \_\_\_\_\_

Their Employer's Name \_\_\_\_\_

Their Birthdate \_\_\_\_\_

Their Dental Insurance Co. \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

## emergency

IN THE EVENT OF AN EMERGENCY, WHO LIVES NEAR YOU THAT WE CAN CONTACT?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone # \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

# dental history

How can we help you today? \_\_\_\_\_

Are you in pain?  Yes  No If so, for how long? \_\_\_\_\_

The approximate date of your last dental visit \_\_\_\_\_

Name of previous dentist \_\_\_\_\_

Your current dental health is  Good  Fair  Poor

Do you like your smile?  Yes  No

Do your gums ever bleed?  Yes  No

Do you grind your teeth?  Yes  No

Have you ever experienced TMJ problems (pain or discomfort in your jaw joints)?  Yes  No

Are you under any unusual stress at home or work?  Yes  No

# medical history

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

The approximate date of your last doctor's visit \_\_\_\_\_

Your current physical health is  Good  Fair  Poor

If you are currently under the care of any physician, please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Are you currently taking or have ever taken any bisphosphonate drugs (Fosamax/Alendronate, Boniva/Ibandronate, Actonel/Risedronate, Aredia/Pamidronate, Zometa/Zoledronate, etc.)?  Yes  No

If yes, please list drug name \_\_\_\_\_ Date(s) taken \_\_\_\_\_

If you are presently taking any other drugs prescribed by a physician or dentist, vitamins and/or herbal supplements, please list: \_\_\_\_\_

Do you need to take antibiotics or be pre-medicated before dental treatment?  Yes  No

Have you ever had any of the following diseases or medical problems? (please circle Yes or No)

Y N Heart Attack/Disease/Stroke	Y N Cortisone Medication	Y N Sjnus Problems
Y N Heart Murmur	Y N Hemophilia/ Abnormal Bleeding	Y N Fever Blisters
Y N Rheumatic Fever	Y N Asthma	Y N Arthritis
Y N Mitral Valve Prolapse	Y N Hepatitis A/B/C	Y N Tuberculosis (TB)
Y N Heart Surgery/Pacemaker	Y N Thyroid/Adrenal Disease	Y N Sickle Cell Disease
Y N Angina	Y N Cancer/Chemotherapy	Y N Joint Prosthesis
Y N Anemia	Y N HIV+/AIDS/ARC	Y N Glaucoma
Y N High/Low Blood Pressure	Y N Diabetes	Y N Psychiatric Problems
Y N Epilepsy/Seizures/ Fainting Spells	Y N Kidney Problems	Y N Drug/Alcohol Abuse

If you have had any other medical problems, please explain \_\_\_\_\_

Are you allergic to any of the following drugs? (please circle Yes or No)

Y N Penicillin	Y N Dental Anesthetics	Y N Tetracycline	Y N Latex
Y N Erythromycin	Y N Aspirin/Ibuprofen	Y N Codeine	

Please list any other allergies \_\_\_\_\_

For women: Are you pregnant?  No  Yes, Week# \_\_\_\_\_

Are you taking birth-control pills?  No  Yes

**IMPORTANT:** I UNDERSTAND THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY PERSONAL INFORMATION, MEDICAL STATUS OR INSURANCE. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT. A FEE OF 1.5% WILL BE CHARGED TO ACCOUNTS 90 DAYS PAST DUE. IN THE EVENT OF COLLECTION ACTION, I AGREE TO PAY A THIRD OF THE OUTSTANDING BALANCE AS ATTORNEY'S FEES.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(If under 18, guardian/account guarantor)

# welcome!

We would like to welcome you and your child to our office.  
Our goal is to make every child's visit pleasant and educational  
Our practice is based on preventive care. We strive to teach good oral care  
that will enable your child to enjoy the magic of a beautiful smile!

## ABOUT YOUR CHILD

1 Name: \_\_\_\_\_  
Last First Middle Initial

Birthday: \_\_\_\_\_  
Month Day Year  Male  Female

Nickname: \_\_\_\_\_

Social Security#: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Apt./Condo# City State Zip Code

School - Town \_\_\_\_\_

College - Full or Part-time \_\_\_\_\_

Referred by: \_\_\_\_\_

## ABOUT YOU

2 Name: \_\_\_\_\_

Social Security#: \_\_\_\_\_

Driver's License # \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Your home phone and address,  
if different from child's: \_\_\_\_\_

Address: \_\_\_\_\_

Birthday: \_\_\_\_\_

Married  Single  Divorced  Widow  Head of House

Employer: \_\_\_\_\_

Address & Town: \_\_\_\_\_

Work phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Beeper/Car phone: \_\_\_\_\_

Send Statement To: \_\_\_\_\_

## DENTAL INSURANCE COMPANY #1

3 Dental insurance Co. #1 \_\_\_\_\_

Address & Town: \_\_\_\_\_

Their phone# \_\_\_\_\_

Group # \_\_\_\_\_

This Dental Insurance is provided through: \_\_\_\_\_

Their Employer's Name: \_\_\_\_\_

Address & Town: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Their Relationship to child: \_\_\_\_\_

Their Social Security# \_\_\_\_\_

Their Birthdate: \_\_\_\_\_  
Month Day Year

## DENTAL INSURANCE COMPANY #2

Dental insurance Co. #2 \_\_\_\_\_

Address & Town: \_\_\_\_\_

Their phone# \_\_\_\_\_

Their Group # \_\_\_\_\_

This Dental Insurance is provided through: \_\_\_\_\_

Their Employer's Name: \_\_\_\_\_

Address & Town: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Their Relationship to child: \_\_\_\_\_

Their Social Security# \_\_\_\_\_

Their Birthdate: \_\_\_\_\_  
Month Day Year

Our Office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.  
(PLEASE COMPLETE OTHER SIDE)

## DENTAL/MEDICAL HISTORY

4 Has your child been to the dentist before?  Yes  No

If yes, the approximate date of last visit: \_\_\_\_\_

Are there any dental problems that you are aware of present?:

Yes  No If yes, please explain: \_\_\_\_\_

Does your child brush his/her teeth daily?  Yes  No

Please rate your child's oral health  Good  Fair  Poor

Is your child currently under the care of a physician?  Yes  No

Child's Physician: \_\_\_\_\_

Their phone #: \_\_\_\_\_

The approximate date last visit: \_\_\_\_\_

Is your child allergic to any drugs?  Yes  No

If yes, please list: \_\_\_\_\_

Is your child taking any prescription drugs?  Yes  No

If yes, please list: \_\_\_\_\_

Does your child need to be premedicated before dental treatment?

Yes  No

6 In the event of an emergency, who should we contact?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Phone #2 \_\_\_\_\_

## 5 Has your child ever had any of the following medical conditions or problems?

Please Circle.

- Y N Heart Murmur/Rheumatic Fever
- Y N Heart problems of any kind.
- Y N Convulsions/Epilepsy
- Y N Cancer
- Y N Diabetes
- Y N Rheumatic Fever
- Y N HIV+/AIDS/ARC
- Y N Hemophilia
- Y N Bleeding problems of any kind
- Y N Hearing Impairment
- Y N Hyperactive
- Y N Any Operations
- Y N Any stays in Hospital.

Are there any other medical conditions or problems relating to your child?

Yes  No If yes, please list: \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

The parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved. A fee of 1.5% will be charge to accounts 60 days past due.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

**Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.**

# Financial Policy



**GRAND DENTAL**  
ASSOCIATES  
**FARNSWORTH**  
DENTAL GROUP  
**CHANNAHON**  
FAMILY DENTISTRY

We are committed to providing you and your family with the best possible dental care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

**Insurance:** We will be happy to process your claims for reimbursement. If we accept assignment for your benefits, you will only be required to pay your estimated co-pay and deductible, or percentage as stated by your insurance company. Payment for your estimated patient portion is expected on the day of service and is payable by Visa, MasterCard, Discover, American Express, Care Credit, check or cash.

We will gladly discuss your proposed treatment and answer any questions we can relating to your insurance benefits. However, you must realize:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to your contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. All policies are different. We have no way of knowing about all of the clauses, limitations and restrictions that may be included in your policy.
- We can not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary benefits, their "usual & customary" maximums, or any other matter related to benefit determination and payments. We will supply factual information regarding services rendered in our office; your carrier will determine benefits.

We must emphasize that as a dental provider, our relationship is with you, the patient, and not your insurance company. While the filing of claims is a courtesy we extend to all of our patients, all fees for services are your responsibility from the date services are rendered. It is to be understood that any amounts not paid by insurance are your responsibility and all charges are due in full within 90 days from the date of service, even if insurance benefits are pending.

**No Shows and Late Cancellations:** We require 48 hours notice for any appointment changes. If you cancel or reschedule without a 48-hour notice, you will be considered a NO SHOW for that visit. **Each patient is allowed one NO SHOW without penalty.** Subsequent NO SHOW appointments will result in a \$68 missed appointment fee being added to your account. *NO SHOW fees are due immediately.* If you are charged for more than one NO SHOW appointment within a year, you will be required to pay a 50% deposit (with a credit card) in order to reserve an appointment. The deposit will be applied to the treatment scheduled or forfeited if the appointment is missed; deposits are non-refundable.

**Minors:** The parent(s) or guardian(s) must accompany a minor for the first visit to our office.

We realize temporary financial problems may affect timely payments on your account. If problems do arise, we encourage you to contact our office promptly for assistance in the management of your account.

Grand Dental Associates  
10020 West Grand Ave.  
Franklin Park, IL 60131  
tel 847.455.8383  
fax 847.455.1265

Farnsworth Dental Group  
1780 North Farnsworth Ave.  
Aurora, IL 60505  
tel 630.898.3610  
fax 630.898.6362

Channahon Family Dentistry  
25206 West Reed St.  
P.O. Box 635  
Channahon, IL 60410  
tel 815.467.1111  
fax 815.467.5999

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Name (printed)

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_GDA \_\_\_FDG \_\_\_CFD

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have been informed of Farnsworth Dental  
Group's Notice of Privacy Practices.

\_\_\_\_\_  
{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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