Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (_____)_____ Pager/Car #: (_____)_____ Work Phone #: (_____)_____ Ext: ____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (_____)_____ Home Phone #: (_____)_____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (_____)_____ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (_____)_____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

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

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen
Y N Antibiotics
Y N Antihistamines
Y N Aspirin
Y N Blood Thinners
Y N Blood Pressure Medication
Y N Cold Remedies
Y N Digitalis/Heart Medication
Y N Insulin/Diabetes Drugs
Y N Nitroglycerin
Y N Recreational Drugs
Y N Steroids/Cortisone
Y N Thyroid Medicine
Y N Tranquilizers

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. ❑ Yes ❑ No

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one: _____

_____

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis/Paget's Disease
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

– OVER –

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (_____) _____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other_____

_____

UPDATES (TO BE FILLED IN AT FUTURE APPOINTMENTS)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

DR. ZORAN D. STOJANOVIC
Distinctive Dentistry of Dundee

OFFICE FINANCIAL POLICY

PLEASE BE PREPARED TO MAKE PAYMENT AT THE CONCLUSION OF EACH APPOINTMENT. YOUR PAYMENT HELPS US HOLD DOWN OUR EXPENSES AND ALLOWS US TO PROVIDE THE EXCLUSIVE CARE YOU NEED AT AFFORDABLE FEES. THANK YOU.

TO BETTER SERVE YOU, WE OFFER THE FOLLOWING GUIDELINES:

1. **PATIENTS WITH INSURANCE:** AS A COURTESY WE FILE TO YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR YOUR **ESTIMATED** CO-PAYMENT AT TIME OF SERVICE.

   A. PAYMENT IN FULL, FOR ALL SERVICES, IS REQUIRED ON INITIAL VISIT. YOUR INSURANCE COMPANY WILL REIMBURSE YOU. THIS GIVES US THE OPPORTUNITY TO GET FAMILIAR WITH YOUR PLAN. INSURANCE VERIFICATION IS NOT A GUARANTEE OF PAYMENT.
   B. YOUR PAYMENT AT TIME OF SERVICE WILL BE DETERMINED BASED ON YOUR INSURANCE COVERAGE.
   C. YOUR **CO-PAYMENT IS ONLY AN ESTIMATE!** YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU/YOUR EMPLOYER AND THE INSURANCE COMPANY.
   ULTIMATELY, YOU ARE RESPONSIBLE FOR ANY ACCOUNT BALANCE.
   D. YOUR INSURER IS REQUIRED TO RESPOND TO CLAIMS WITHIN 30 DAYS. BALANCES PERSISTING BEYOND 60 DAYS BECOME PATIENT'S RESPONSIBILITY.
   ALL BALANCES MUST BE PAID WITHIN 60 DAYS OF DATE OF SERVICE.

2. **PATIENTS WITHOUT INSURANCE:**

   A. SINGLE VISIT TREATMENT MUST BE PAID IN FULL AT EACH VISIT.
   B. FOR MULTIPLE VISIT TREATMENT, YOU WILL BE RESPONSIBLE FOR 50% OF TREATMENT AND BALANCE OF 50% MUST BE PAID ONE WEEK PRIOR TO SCHEDULED APPOINTMENT (COMPLETION).

3. **PAYMENTS AND DISCOUNTS:**

   A. **WE ACCEPT CASH, CHECK AND MAJOR CREDIT CARDS.**
   B. CARE CREDIT, IS A CREDIT LINE USED EXCLUSIVELY FOR YOUR DENTAL EXPENSE. AN APPLICATION AND CREDIT CHECK WILL BE REQUIRED. MAXIMUM 12 MONTHS INTEREST FREE.
   C. 10% DISCOUNT FOR PAYMENT IN FULL OF ENTIRE TREATMENT PLAN ($4000 MIN.) PAID ONE WEEK PRIOR TO START OF TREATMENT. ONLY 5% DISCOUNT IF PAID WITH CREDIT CARD.
   D. SENIOR CITIZENS (AGE 65+) RECEIVE 10% DISCOUNT FOR PAYMENT IN FULL. (5% DISCOUNT IF PAYING WITH CREDIT CARD).

4.. **IMPORTANT INFORMATION ABOUT OUR PRACTICE:**

   A. I AUTHORIZE DR. ZORAN D. STOJANOVIC TO ACCESS A CREDIT REPORT, IF NECESSARY.
   B. A MONTHLY LATE CHARGE OF $15.00 IS ASSESSED FOR ALL BALANCES BEYOND 60 DAYS. ANY BALANCE CARRIED BEYOND 90 DAYS WILL BE TURNED OVER TO OUR COLLECTION AGENCY. ACCOUNTS ARE REPORTED TO THE CREDIT BUREAU AND THIS WILL AFFECT YOUR CREDIT HISTORY.
   C. **A $75.00 FEE, PER HOUR, IS CHARGED FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE.**

I AGREE TO THESE TERMS_____

PATIENT SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

#J312

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).