Chicago Dental Implants,
Oral & Facial Surgery

Patient's Name: ________________________ Date of Birth: ________________

Street Address: ________________________ S.S. #: ________________

City: ________________________ State: ________ Zip Code: ________________

Home Phone: (______)________________________ Work Phone: (______)________________

Are you a Full-Time College Student? ☐ Yes ☐ No Name of College: ________________

Referring Dentist/Doctor: ________________________ City: ________________

General Dentist: ________________________ City: ________________

If NOT referred by a Dentist, how did you hear about us? ________________________

RESPONSIBLE PARTY (Policyholder and/or Guarantor)

Person Responsible for Account: ________________ Policyholder's Name: ________________

Address (if different from above): ____

Policyholder's Employer: ________________ Policyholder's Work Phone: ___(______)________________

Policyholder's S.S.#: ________________ Policyholder's Date of Birth: ________________

DENTAL INSURANCE

Name of Insurance: ________________________ Phone: (______)________________

Mailing Address: ____

City: ________________________ State: ________ Zip Code: ________________

Policyholder's Name: ________________________ Date of Birth: ________________

Employer: ________________ I.D. #: ________________ Group #: ________________

MEDICAL INSURANCE

Name of Insurance: ________________________ Phone: (______)________________

Mailing Address: ____

City: ________________________ State: ________ Zip Code: ________________

Policyholder's Name: ________________________ Date of Birth: ________________

Employer: ________________ I.D. #: ________________ Group #: ________________

NOTE: Assignment of Benefits and Release of Information MUST BE SIGNED if we are filing Insurance for you.

I authorize payment of benefits to the above named provider for professional service and I authorize release of any information.

Signed: ________________________________ Date: ________________________

HEALTH HISTORY FORM

Patient's Name: ______________________________ Date of Birth: ____________________

Gender: ☐ Male ☐ Female Height: ____________ Weight: ____________

Your medical history is important to the treatment you will receive, it is important that you respond to each question honestly and completely.

Please describe the symptoms you are currently having today: ______________________________

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No

If yes, why?:______________________________

Are you now under a physician's care for a particular problem at this time? ☐ Yes ☐ No

If yes, why?:______________________________ Date of last physical exam:____________

Physician's Name: ______________________________ Physician's Phone Number: ____________

Address:____________ City:____________ State:______ Zip Code:____________

Preferred Pharmacy: ______________________________ Phone Number: ____________

Address:____________ City:____________ State:______ Zip Code:____________

PATIENT MEDICAL HISTORY

Do you have or have you ever had?

	Yes	No
Congenital heart disease, cardiovascular disease (heart attack), heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, and peacemaker?	☐	☐
Artificial implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	☐	☐
Kidney disease or kidney failure, requiring dialysis?	☐	☐
Thyroid disease?	☐	☐
Stomach ulcers or colitis?	☐	☐
Clicking, popping, or pain within the jaw joint, and/or difficulty opening mouth?	☐	☐
Frequent or recurring mouth sores?	☐	☐
Sinus or nasal problems?	☐	☐

Please list all medical conditions:

	Yes	No
Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, sleep apnea, tuberculosis, shortness of breath, chest pain, severe coughing)?	☐	☐
Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	☐	☐
Liver disease (jaundice, hepatitis A, B, or C)?	☐	☐
Diabetes?	☐	☐
Arthritis?	☐	☐
Osteoporosis or osteopenia?		
Radiation to the head or neck for cancer treatment?	☐	☐
Any disease, chemotherapy or transplant operations? Cancer? If so where on the body?	☐	☐

____

Last treatment date: ____________________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? ☐ Yes ☐ No

MEDICATIONS

Are you using any of the following?

	Yes	No
Antibiotics?	☐	☐
Anticoagulants (blood thinners)?	☐	☐
Heart drugs?	☐	☐
Steroids (cortisone, prednisone, etc.), anti-anxiety agents, sedative-hypnotics, and antidepressants?	☐	☐
Prescription pain medication?	☐	☐
Aspirin or dugs such as Motrin, Aleve, Ibuprofen?	☐	☐
Insulin or oral anti-diabetic drugs?	☐	☐
High blood pressure medications?	☐	☐
Bisphosphonates, antiangiogenic, and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers?	☐	☐

If yes, list drugs used and time of use.

Please list any medications you are currently taking, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins, or minerals:

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

	Yes	No
Latex?	☐	☐
Sedative, barbiturates?	☐	☐
Codeine or other pain killers?	☐	☐
Antibiotic?	☐	☐

If yes, which one(s):

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedations?

☐ Yes ☐ No If yes, which anesthetic? ________________________________ Relationship: ______________________

Other drug allergies no listed above:

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? ☐ Yes ☐ No If yes, how long? ______________________________________

Have you ever sought professional care or been hospitalized for:

	Yes	No	
Drug abuse?	☐	☐	___________________
Emotional disorders?	☐	☐	___________________
Alcoholism?	☐	☐	___________________
Alcohol?	☐	☐	____________________
Marijuana?	☐	☐	____________________
Recreational drugs?	☐	☐	____________________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? ☐ Yes ☐ No If yes, please explain: ______________________

Do you wish to talk to the doctor privately about anything? ☐ Yes ☐ No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

Signature Patient, Parent, Guardian ____ Date ___________________________

Printed Name of Patient, Parent, Guardian/Relationship ________________________________ Doctor's Signature _________________________

CONFIDENTIAL COMMUNICATION

Patient's Name: ____ Date of Birth: ______________________

I request that all communication to me by CDI Oral & Facial Surgery and/or his staff be handled in the following manner:

Written Communication: Address to:

Oral Communication: Cell #: ______________________________ May we leave a message? ☐ Yes ☐ No

Home #: ______________________________ May we leave a message? ☐ Yes ☐ No

Work #: ______________________________ May we leave a message? ☐ Yes ☐ No

Email Communication: ___________________________ May we communicate with you through e-mail? ☐ Yes ☐ No

RESPONSIBLE PARTY (Policyholder and/or Guarantor)

Person responsible for Account: ________________________ Policyholder's Name: ______________________

FOR PATIENTS 18 AND OVER

I allow CDI Oral & Facial Surgery and/or Staff to communicate with the following people regarding my Treatment and/or my Account:

Name: _______________________ Phone #: _________________ Relationship: ☐ Parent ☐ Spouse ☐ Caregiver

Name: _______________________ Phone #: _________________ Relationship: ☐ Parent ☐ Spouse ☐ Caregiver

Name: _______________________ Phone #: _________________ Relationship: ☐ Parent ☐ Spouse ☐ Caregiver

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the 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 amount the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operation 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 Practice from time to time and that I many contact this organization at any time at the address listed for contact person to obtain a current copy of the 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 requested restriction, but if you do agree that you are bound to abide by such restrictions.

Print Patient Name: ___________________________ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Caregiver

Signature: ____ Date: ___________________________

FINANCIAL AND INSURANCE

We are committed to providing you with the best possible care. If you have dental or medical insurance, we will help you receive your maximum allowable benefits. We will be happy to help you process your insurance claim if you provide us with complete insurance information. However, please keep this in mind:

1. Your insurance is a contract between you and your insurance carrier.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies.
3. Not all services are a covered benefit in all insurance policies.
4. Medical insurance may pay for complete boney impacted extractions.
5. The providers at CDI Oral & Facial Surgery are not enrolled with Medicare, as well as any Supplemental with Medicare. If your service is medical, we can refer you to a provider who is enrolled in Medicare for your medical service. CDI Oral & Facial Surgery providers are not enrolled with Medicare; therefore, we will not be able to utilize your supplemental insurance.
6. The providers at CDI Oral & Facial Surgery are enrolled in some HMO and/or DMO plans. However, we cannot submit claims to them without a specialty referral from your primary care physician.
7. The providers at CDI Oral & Facial Surgery are in-network providers with most but not all dental insurance plans. We will submit claims to them for you on your behalf.

"WITH" INSURANCE COVERAGE

Patients who provide us with complete insurance coverage information will be required to pay your estimated portion due when scheduling your surgical visit.

Please note, the total fee is your obligation, once your insurance has responded, any difference is your responsibility. If your insurance carrier has not paid within 60-days following the claim, the entire balance is due and payable at that time. Any balances not paid in full will incur an interest fee and if any balance remains unpaid and is sent to collections, there may be additional collection fees accrued, which will also be your responsibility. If there is an overpayment once insurance has paid, this will be refunded to you in the original form of payment.

"NO" INSURANCE"

Patients who do not have dental insurance will be required to make full payment at the time the service is rendered. If this is not possible, we do work with several financing companies, and can will provide you with additional information on the payment options.

We currently work with Sunbit and also Care Credit. For more information on Sunbit, go to Sunbit.com or call our office and we can send you a pre-qualification link. For approval with Care Credit, go to Carecredit.com and fill out the online application to find out what the amount of credit you have been approved for (to utilize your account, you must have the approved account number with you at time of appointment).

CANCELLATIONS / NO SHOW APPOINTMENTS:

Our office requires a **48-hour cancellation notice**. If you cancel your appointment with **less than a 24-hour notice** or fail to call and/or miss your appointment, there will be a fee charged to your account. If appropriate notice is not given, a **charge of $75** will be assessed to your account. For any missed Surgeries, there will be a **30% charge** taken from your Treatment Plan. We understand that sometimes last-minute cancellations are unavoidable; therefore, individual circumstances may be discussed with the office manager.

Signature: ____ Date: ______________________________