Wood Dale Dental
142 W. Irving Park Rd.
Wood Dale, IL 60191
p. 630.426.7652
f. 630.766.5424

New Patient Intake Form

First Name | Last Name | Middle Initial

Patient Is ☐ Policy Holder ☐ Responsible Party | Preferred Name

Responsible Party (if someone other than the patient)

First Name | Last Name | Middle Initial

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Birth Date | Social Security Number | Driver's License Number

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Sex: ☐ Male ☐ Female | Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date | Age | Social Security # | Driver's License #

Email ☐ I would like to receive correspondences via e-mail

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired | Student Status: ☐ Full Time ☐ Part Time

Medicaid ID | Employer ID | Carrier ID

Preferred Dentist | Preferred Hygienist

Preferred Pharmacy | Previous Dentist

Emergency Contact Name | Emergency Contact Phone #

How did you find us? *(check all that apply)*

Internet __ Google __ Bing __ Facebook **Other** __ Friend/Family __ Doctor/Health Professional __ Saw The Sign Out Front

Who?_____

Primary Insurance Information

Name of Insured	Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
Insured Social Security #	Insured Birth Date		
Employer Name	Address		
Address 2	City	State	Zip
Insurance Company	Address		
Address 2	City	State	Zip
Remaining Benefits	Remaining Deductible		

Secondary Insurance Information

Name of Insured	Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other		
Insured Social Security #	Insured Birth Date		
Employer Name	Address		
Address 2	City	State	Zip
Insurance Company	Address		
Address 2	City	State	Zip
Remaining Benefits	Remaining Deductible		

Agreement For Payment And Authorization

I, the patient understand that I am financially responsible to Wood Dale Dental for any covered or non-covered services as defined by my insurer, which are not paid by my primary. I hereby authorize and assign payment to be made directly to Wood Dale Dental. I understand that all treatment plans provided are subject to change if further treatment is needed, I hereby authorize and assign payment to be made to Wood Dale Dental.

I further understand, acknowledge and accept that if I fail to appear at my scheduled appointment without providing 24 hour notice or my failure to appear at my scheduled appointment is not a result of a health emergency, I agree to apply $50 for each half hour for the missed appointment.

I also understand that if my account balance becomes overdue past 30 days and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance may be added to the amount due and that I am financially responsible for the added collection fee. In the event the overdue account is referred to a collection agency, I understand, accept and agree a $100.00 administrative fee to Wood Dale Dental will be added to the overdue balance, which I am financially responsible to pay. I am also responsible for the interest at the rate of one and one half percent per month on the overdue balance, together with all the cost incurred for the collection of the amounts due and owing. It is agreed that Wood Dale Dental will continue to treat me as long as payment is made pursuant to this agreement. In the event payment is not made when due, or in the event of discharge in bankruptcy, Wood Dale Dental has the right to place me in a maintenance status and terminate further treatment.

Authorization For Release Of Medical Information

I hereby authorize Wood Dale Dental to release any information required in the processing of applications for insurance coverage for services rendered. This authorization provides for the release of objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

Consent For Treatment

I hereby consent to treatment provided by Wood Dale Dental, its practices, employees or designees and authorize medical and surgical services, diagnostic procedures and medications as designed necessary or advisable by the practitioners providing treatment.

Patient Acknowledgment

I have read this agreement/authorization form and I understand its contents. I have had the opportunity to discuss the contents of this form and that any verbal statement may not alter the contents of this form. My signature confirms that I fully accept and acknowledge each section of this form.

_____	_____	_____	_____
(Patient's Signature)	(Date)	(Guardian or Responsible Party's Signature)	(Date)

Wood Dale Dental
142 W. Irving Park Rd.
Wood Dale, IL 60191
p. 630.426.7652
f. 630.766.5424

Notice of Privacy Practices

Patient Name	Date of Birth

I have received the practice's notice of privacy written in plain language. The notice provides in detail the uses and disclosure of my protected health information that my be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that the practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Type of users and disclosure that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations
- A description of each of the purposes for which this practice is permitted or required to use or disclose protected health information without a written consent or authorization
- A description of other users and disclosures that are prohibited or materially limited by law
- A description of other users and disclosures that will be made only with my written authorization and that my revoke such authorization.
- My individual rights with respect to protected health information and brief descriptions of how I may exercise these rights in relation to:
    - The rights to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to request restriction.
    - The right to inspect and copy protected health information
    - The right to receive and accounting disclosure of protected health information.

This practice reserves the right to change the terms of its Notice of Privacy and to make new provisions effective for all protected health information that it maintains. I understand I can obtain this practice's current Notice of Privacy Practices on request.

_____	_____	_____	_____
(Patient's Signature)	(Date)	(Guardian or Responsible Party's Signature)	(Date)

Wood Dale Dental
142 W. Irving Park Rd.
Wood Dale, IL 60191
p. 630.426.7652
f. 630.766.5424

Medical History

Are you under a physician's care now? ☐ Yes ☐ No — If Yes,

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No — If Yes,

Have you ever had a serious head or neck injury? ☐ Yes ☐ No — If Yes,

Are you taking any medications, pills or drugs? ☐ Yes ☐ No — If Yes,

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No — If Yes,

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No — If Yes,

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No — If Yes,

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to... ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Are you allergic to anything else? If yes,

Do you have or have you had any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy/Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No

Have you ever had any serious illness not listed above? If yes,

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ (Patient's Signature) _____ (Date) _____ (Guardian or Responsible Party's Signature) _____ (Date)