# Orland Dental Care

14360 S. LaGrange Road | Unit C • Orland Park, IL 60462 (708)364-8900

**Welcome to our Practice**

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** ___-__-____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**The following is for:** ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

**Employer Name:** _____ **Phone:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

**In an emergency who should be notified? Please enter Name and Phone number below:**

_____

_____

## Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Allergy Codeine
- ☐ Allergy Cyndamyacin
- ☐ Allergy Demeral
- ☐ Allergy Penicillin
- ☐ Amoxicillin Allergy
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asprin Allergy
- ☐ Asthma
- ☐ Augmentin allergy
- ☐ Bactrim Allergy
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eggs
- ☐ Epilepsy
- ☐ Erythromycin Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hyper/Hypothyroidism
- ☐ Ibuphrohen allergy
- ☐ Ibuprophen
- ☐ Iodine Allergy
- ☐ Jaundice
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Morphine Allergy
- ☐ Nervous Disorders
- ☐ Nuts
- ☐ Pacemaker
- ☐ peanut
- ☐ Pregnancy
- ☐ Pre-med
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortmess of Breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tetracycline Allergy
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Versed Allergy

☐ Do you Smoke? ☐ FEMALE: Pregnant ☐ FEMALE: Nursing

**If any conditions or alerts selected above need further clarification, please describe below:**

_____

_____

**Do you take antibiotic premedication for your dental visits? If yes, please explain.**

_____

_____

**Name of your physician and phone number:**

_____

_____

**Are you under a physician's care? *** ◯ Yes ◯ No

**Reason:**

_____

_____

**List all medications (prescription and non-prescription) including regular doses of aspirin:**

_____

_____

_____

**Any Allergies to Medications or Substances? Please list:**

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

**Print Name and Date: ***

## Consent for Services and Financial Policy

Thank you for choosing Orland Dental Care for your dental needs. We understand everyone's financial situation is different. For this reason, we have worked hard to provide you with a variety of payment options to help you receive the dental care you need and deserve with respect to your budget. As a courtesy we will bill your dental insurance but cannot guarantee payment. Payment is due at the time of service and pre-payment is due for future visits.

Low monthly payment plans are offered from 6 to 24 months at 0% interest. For your convenience we accept Visa, Mastercard, American Express, Discover, ATM/debit cards, as well as cash and check.

If you do not have dental insurance your payment is due on or around the time of service. We will be happy to arrange a payment plan with you. Also, our office is happy to submit insurance claims for you. We will also be glad to go over an ESTIMATED cost of your dental services. It is important for you to know that we bill insurance companies as a courtesy and cannot be held responsible if they do not pay or receive claims in a reasonable amount of time. It is also important for you to know that we do estimate your portions on the information your insurance companies give us. It is not a guarantee that is what they will cover. We accept both managed care and standard insurance plans. Please keep in mind that most insurance companies do not cover 100% of dental procedures. We encourage you to discuss and understand your dental insurance along with your insurance company. Any questions regarding your treatment plan should be discussed with your dentist.

☐ * **By checking this box, I signify I have read and understand Orland Dental Care's policy regarding payment.**

**PLEASE READ AND CHECK EACH BOX SHOWING YOU UNDERSTAND THE FOLLOWING:**

☐ * **I understand that my insurance policy may, or may not cover all dental services and that it is my responsibility to call my insurance company to verify mine as well as my family's coverage on dental procedures to be performed on myself or my family.**

☐ * **My insurance plan may have a deductible and/or co-payment amount which is due at the time of service. I understand that I will be responsible for any other portions not covered by my insurance company.**

☐ * **Any flex plan reimbursement will be paid directly to me upon submission of my paid receipts to my company.**

☐ * **I accept full responsibility for all fees required for my dependent's dental needs, regardless of my martial status.**

☐ * **I understand there is a charge for failing or cancelling an appointment without a 24 hour notice given.**

☐ * **I understand there is a charge of $35.00 to copy x-rays.**

☐ * **I understand that there is a charge of $25.00 for any checks returned from my bank, which will be added to my account. I also understand in the event of this happening I will be asked to pay by credit card, cash, or money order for the returned amount.**

☐ * **I understand that I am responsible for any fees, expenses or cost related to collection of any unpaid balances. Including, but not limited to late charges, referral costs and commission paid to attorneys or collection agencies.**

☐ * **I hereby authorize this office to take radiographs, study models, photographs or any other diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be needed. I further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embody a certain risk.**

☐ * **I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is my responsibility and that payment is due at the time services are rendered. I further understand that finance charges may be added to any account that is 90 days past due. In the event of default I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an addition 50% of balance added for collection costs as will be required to effect collection of this account.**

**Print Name and Date: ***

## HIPAA Acknowledgement

Please see the person at the front desk if you are interested in reading the Notice of Privacy Practices. This notice describes how health information about you may be used and disclosed and how you can access this information.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

**If a personal representative for this authorization on behalf of the individual, complete the following; Personal Rep's Name and relation to individual:**

**Response Date: ____/____/_____**