

# 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.

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