



# WOODLAKE FAMILY DENTAL

A Multi- Specialty Office for All Ages  
3253 S. Harlem Ave, Suite 1C Berwyn, IL 60402

## Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

### Patient Information

Name (Last, First MI.) \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Sex M/F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Other \_\_\_  
Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone # \_\_\_\_\_  
Business Email \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Notify in case of emergency \_\_\_\_\_ Home # \_\_\_\_\_  
Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

### Primary Dental Insurance

Person Responsible for Account \_\_\_\_\_  
Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_  
Address(if different from patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_  
Cell phone \_\_\_\_\_ Email \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business phone \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Ins. # \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of dependents under this plan \_\_\_\_\_

### Additional Dental Insurance

Is patient covered by additional dental insurance? Y/N Subscriber Name \_\_\_\_\_  
Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Ph.# \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone# \_\_\_\_\_  
Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Patient Name: \_\_\_\_\_

## Dental History

What would you like us to do today? \_\_\_\_\_

Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Circle Y/N if you have had any of the following:

Y/N Bad Breath	Y/N Sensitivity to cold /Hot
Y/N Food collection between teeth	Y/N Sensitivity when biting
Y/N Periodontal treatment	Y/N Clicking or popping jaw
Y/N Sensitivity to sweets	Y/N Loose teeth or broken fillings
Y/N Bleeding gums	Y/N Sores or growth in mouth
Y/N Grinding or clenching teeth	

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

Y/N If yes, explain \_\_\_\_\_

Other information about your dental health or previous treatment \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last visit \_\_\_\_\_

Have you ever had any serious illnesses or operations? Y/N If yes, describe \_\_\_\_\_

Are you currently under physician care? Y/N If yes, describe \_\_\_\_\_

Have you ever been required to take antibiotics before a dental appointment? Y/N

Have you ever had a blood transfusion? Y/N If yes, give approx. dates \_\_\_\_\_

Women: Are you pregnant? Y/N Nursing? Y/N Taking birth control pills? Y/N

Circle Y/N whether you have had any of the following:

Y/N AIDS/HIV Positive	Y/N Headaches	Y/N Radiation Treatment
Y/N Anaphylaxis	Y/N Heart Murmur	Y/N Respiratory Disease
Y/N Anemia	Y/N Heart Problems	Y/N Rheumatic/Scarlet Fever
Y/N Arthritis, Rheumatism	Y/N Hemophilia/Abnormal Bleeding	Y/N Shortness of Breath
Y/N Artificial Heart Valves	Y/N Herpes	Y/N Spina Bifida
Y/N Artificial Joints	Y/N Hepatitis	Y/N Stroke
Y/N Asthma	Y/N High Blood Pressure	Y/N Surgical Implant
Y/N Back Problems	Y/N Jaw Pain	Y/N Thyroid Disease Hyper/Hypo
Y/N Blood Disease	Y/N Kidney Disease or Malfunction	Y/N Seizure
Y/N Cancer	Y/N Rapid Weight Gain/Loss	Y/N Tuberculosis
Y/N Liver Disease	Y/N Tobacco Habit	Y/N Ulcer/Colitis
Y/N Chemotherapy	Y/N Material Allergies (Latex, Metal)	Y/N Venereal Disease
Y/N Circulatory Problems	Y/N Mitral Valve Prolapse	Y/N Glaucoma
Y/N Cortisone Treatments	Y/N Nervous Problems	Y/N Heart Surgery
Y/N Diabetes	Y/N Pacemaker	
Y/N Epilepsy	Y/N Psychiatric Care	

Is patient currently taking any medications? Y/N If yes, please list all:

Does patient have any drug allergies? Y/N If yes, please list all:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on the first page of these forms to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Financial Policy

### **All co-payments are due at the time services are rendered.**

As a condition of your treatment by this office, financial arrangements must be made in advance. Our office accepts assignment of insurance benefits. We verify eligibility and coverage for all insurances: if your insurance company is expected to pay a portion of your bill, we will wait for that portion from them. It is your responsibility to pay co pays, deductibles, and any amount not expected from your insurance at the time treatment is provided. If your insurance company has not paid the full balance within 60 days, the balance of your account will become your responsibility. If you do not have insurance, or if our office does not accept assignment from your insurance company then payment is due in full at the time of treatment.

**We are a third party administrator of your insurance carrier and are NOT responsible for how your insurance handles your claims or how benefits are assigned. We can assist in estimating the cost of your portion of treatment but cannot be responsible for any changes in your insurance policy or benefits used elsewhere. It is your responsibility to let us know if your insurance has changed, terminated or have used dental benefits elsewhere. Please remember that insurance is a contract between you and your insurance company. Our office is not a part of this contract. You are responsible for the timely payment of your account.**

Our office accepts Cash, Visa, MasterCard, Discover, American Express, and Care Credit. **NO CHECK PAYMENTS.**

In this office we believe in providing our patients with the utmost care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however this is a mercury-free office, and the patient is responsible for any difference in cost.

## **X-rays and Photographs**

I authorize Woodlake Family Dental to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary to processing my dental claim (if applicable and according to HIPPA regulations).

## Cancelation Policy

**If you find it impossible to keep an appointment, for consideration of other patient's needs, we ask for a 48 hour notice. Appointments canceled or missed without a 48 hour notice are subject to a missed appointment fee.** We believe that the dental appointment represents a shared responsibility for both the doctor and the patient in order to have quality dental care at an affordable cost, these appointments must be kept. If an appointment is not kept or is changed within 48 hours, future appointments will only be held if you contact our office to confirm those appointments. If you fail to confirm your appointments, our office reserves the right to cancel your appointment or those of your family members. After two missed appointments, we will no longer be able to reserve appointment time for you in advance.

Thank you for understanding our Financial Policy and Cancellation Policy.  
I have read the above and fully understand the terms stated above.

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SIGNATURE

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DATE



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_, hereby acknowledge receipt of Woodlake Family Dental's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the office may use and disclose my confidential information.

Print Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature(Parent or Guardian if patient is a minor):

\_\_\_\_\_  
Date:

## REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**The best way to contact me by Woodlake Family Dental's staff is:**

Written communication: Address to: \_\_\_\_\_

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

Oral communication: Call Home # \_\_\_\_\_  
May we leave a message? Yes \_\_\_ No \_\_\_

Work # \_\_\_\_\_  
May we leave a message? Yes \_\_\_ No \_\_\_

Cell # \_\_\_\_\_  
May we leave a message? Yes \_\_\_ No \_\_\_

Oral Communication: Call

May we leave a message that you need pre-medication? Yes \_\_\_ No \_\_\_

May we leave a message that you need a dental appointment? Yes \_\_\_ No \_\_\_