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	Sensitivity to sweets	Y/N	Loose teeth or broken fillings
Y/N	Grinding or clenching teeth	Y/N	Bleeding gums
Y/N	Sores or growth in mouth	Y/N	Clicking or popping jaw

How often does your child brush? ___________ Do you assist?_________
Floss?_________________
How do you feel about the appearance of your child's teeth? ___________________________________
Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y/N If yes, explain ____
Other information about your child's dental health or previous treatment _________________________

Medical History

Physician's Name _______________________________ Phone___________________________
Date of last visit ____
Has your child ever had any serious illnesses or operations? Y/N If yes, describe __________________
Has your child ever had to be hospitalized? Y/N If yes, describe ______________________________Has your child been to the ER within the last year? Y/N If yes, describe ________________________
Is your child's immunizations up to date? Y/N ____
Is your child currently under physician care? Y/N If yes, describe _____________________________
Has your child ever been required to take antibiotics before a dental appointment? Y/N
Has your child ever had a blood transfusion? Y/N If yes, give approx. dates ______________________

Circle Y/N whether your child has had any of the following:

Y/N	Asthma	Y/N	Congenital Heart Disease	Y/N	Seizure Disorder
Y/N	Anemia	Y/N	Heart Murmur	Y/N	Depression
Y/N	Hemophilia/Abnormal Bleeding	Y/N	Rheumatic Fever/Scarlet Fever	Y/N	Diagnosed Anxiety
Y/N	Arthritis, Rheumatism	Y/N	Artificial Heart Valves	Y/N	Autism
Y/N	Sickle Cell Disease/Trait	Y/N	High Blood Pressure	Y/N	Sensory Disorder
Y/N	AIDS/HIV Positive	Y/N	Kidney Disease or Malfunction	Y/N	Learning Disability
Y/N	Immune compromised	Y/N	Hepatitis	Y/N	Developmental Delay
Y/N	Cancer	Y/N	Liver Disease	Y/N	ADD/ADHA
Y/N	Radiation Treatment	Y/N	Diabetes I or II	Y/N	Speech Impairment/Delay
Y/N	Chemotherapy	Y/N	Ulcer/Colitis	Y/N	Cerebral Palsy
Y/N	Food Allergies	Y/N	Recurrent Ear Infections	Y/N	Spina Bifida
Y/N	Seasonal Allergies	Y/N	Hearing Impairment	Y/N	Hydrocephalus
Y/N	Congenital Birth Defect	Y/N	Vision Impairment	Y/N	Thyroid Disorder
Y/N	Cleft Lip/Palate	Y/N	Down Syndrome	Y/N	Sleep Apnea
Y/N	Premature Birth	Y/N	Anaphylaxis	Y/N	Excema

Does your child have any special limitations either mental or physical not included above Y/N: describe:
____

Does your child currently taking any medications? Y/N If yes, please list all:

____

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

____

Did you have any problems during your pregnancy? If yes, please explain:

____

Was there any complications with the birth of your child? If yes, please explain:

____

Did you or are you breast feeding your child? If yes, until what age:

____

Has your child ever fallen and bumped mouth or teeth? Y/N If yes, describe:______________________

Does your child have an oral habit (pacifier, thumb/finger sucking, tongue thrust, etc) Y/N, If yes describe:

____

How many ounces does your child drink a day of:

Juice(watered down or straight): _________	Milk: ________
Tap Water: _____________	Chocolate Milk: __________
Bottle Water:____________	Soda:___________
Gatorade: ____________	Ice Tea/Tea/Coffee:

Does your child take multivitamins? Y/N If yes, what kind:_____________________________

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 ________________

WOODLAKE FAMILY DENTAL

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

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.

____________________________________ ____________________

SIGNATURE DATE

WOODLAKE
FAMILY DENTAL

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

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 CONFINDENTIAL 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 ____

INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT

One of our most important parental policies is to "inform before we perform." Before we begin treating your child, we ask your permission for periodic dental examinations, x-rays, dental cleanings and fluoride applications. We also need your permission to perform dental treatments, restorations and/or appliances as needed to return all teeth to health and proper function, using local anesthetic and a comfortable mouth prop. The purpose of all these procedures is to gain and maintain dental health, and we expect good results, although no guarantees as to the results may be given.

Although our goal is the best oral health for your child, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

A visit to the dental office presents the young child with lots of new and unfamiliar experiences. It is completely normal for some children to react to these new experiences by crying. All efforts will be made to gain the confidence and cooperation of our young patients by warmth, humor, gentle understanding and friendly persuasion. High quality dental care for children is our goal. Quality care can be made very difficult or even impossible, by the lack of cooperation. Behaviors that can interfere with proper dental treatment are hyperactivity, resistive movements, refusing to open the mouth or keep it open, and even aggressive or physical resistance to treatment. Aggressive or physical resistance to treatment can be screaming, hitting, kicking and grabbing the dentist's hands or grabbing our sharp dental instruments.

There are several behavior management techniques that are used in our office to help children get the quality dental care they need. Let us tell you about them:

a. TELL-SHOW-DO is the use of simple explanations and demonstrations, geared to the child's level of maturity.

b. POSITIVE REINFORCEMENT is rewarding the helpful child with compliments, praise, a hug or a prize.

c. VOICE CONTROL is getting the attention of a noisy child by using firm commands and varying tones of voice.

d. PHYSICAL RESTRAINT BY THE DENTAL TEAM. With an active and noisy child, it is sometimes necessary for the dental assistant to restrain the child's movement by holding the head, arms, hands or legs. The dentist may restrain the child's head by stabilizing it between arm and body. A rubber or plastic mouth prop is placed in the child's mouth to prevent closing when the child refuses to open or has trouble keeping the mouth open.

e. PHYSICAL RESTRAINT BY PAPOOSE BOARD OR PEDI-WRAP. The use of this type of restraint is a standard of care in medicine. The Papoose Board or Pedi-wrap is the safest and most compassionate way to ensure quality dental treatment of an active child. It holds arms, body and legs secure with Velcro and cloth wraps during treatment

f, LAUGHING GAS. The use of laughing gas (nitrous oxide) is another safe way to provide dental treatment to mildly frightened, but helpful children. Laughing gas calms children, but does not put them to sleep or numb their teeth. It has few side effects and lasts only as long as the gas is being given through a nose mask. On rare occasions, the gas can cause an upset stomach and vomiting.

Beyond these techniques, a child with disruptive behavior may need dental treatment with sedation or treatment in a hospital, which is covered in a separate consent form.

I have read and understand this information on behavior management. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatments in terms appropriate to their age. If any treatment other than the above is needed, it will be discussed with me before beginning such treatment. I understand that I may refuse any or all of the above treatments or procedures. I can do this by drawing a line through the objectionable part and writing my initials next to the portion to which I refuse to consent. This consent will remain in full force unless withdrawn in writing by the person who has signed on behalf of this minor patient.

____________________	____________________	____________________
PRINT CHILD'S NAME	PARENT OR GUARDIAN'S SIGNATURE	TODAY'S DATE

____

WITNESS