Randall Oaks Dental

Medical History Form v2020.1

Patient Name: Birth Date: Date Created:

PATIENT INFORMATION

Do you have a physician? (Please include doctor's name and phone number)	◯ Yes ◯ No	If yes
Date of last visit with physician:		
Are you in poor health?	◯ Yes ◯ No	
Are you currently under the care of a physician? Why?	◯ Yes ◯ No	If yes
Have you ever been diagnosed with sleep apnea?	◯ Yes ◯ No	
Do you use tobacco in any form? How much per day?	◯ Yes ◯ No	If yes
Have you ever had any surgical procedures? Please list year and procedure.	◯ Yes ◯ No	If yes
Are you taking medications? Please list below.	◯ Yes ◯ No	

MEDICAL HISTORY

Conditions

Abnormal Bleeding	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Alcohol Abuse	◯ Yes ◯ No	Facial Surgery	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Fainting Spells	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Fever Blisters	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Angina Pectoris	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Pace Maker	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	HIV + AIDS	◯ Yes ◯ No	Radiation Therapy	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Attack	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Heart Surgery	◯ Yes ◯ No	Sexually Transmitted Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Colitis	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Congenitial Heart Defect	◯ Yes ◯ No	Hepatitis B	◯ Yes ◯ No	Sinus Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis C	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Difficulty Breathing	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No
Drug Abuse	◯ Yes ◯ No	Joint Replacement	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No

Allergies

Acrylic	◯ Yes ◯ No	Dental Anesthetic	◯ Yes ◯ No	Latex	◯ Yes ◯ No	Penicillin/Amoxicillin	◯ Yes ◯ No
Aspirin	◯ Yes ◯ No	Erythromycin	◯ Yes ◯ No	Metals	◯ Yes ◯ No	Tetracycline	◯ Yes ◯ No
Codeine	◯ Yes ◯ No	Jewelry	◯ Yes ◯ No				

Women: Are you...

Pregnant/Trying to get pregnant?	◯ Yes ◯ No	Nursing?	◯ Yes ◯ No	Taking oral contraceptives?	◯ Yes ◯ No

DENTAL HISTORY

Your current dental health is (please check ONLY one):

☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? Why?	◯ Yes ◯ No	If yes	
Do your gums bleed?	◯ Yes ◯ No		
Have you ever had gum disease?	◯ Yes ◯ No		
Are you currently in pain?	◯ Yes ◯ No	If yes	
Have you had any pain/discomfort in your jaw joint (TMJ)?	◯ Yes ◯ No		
Are you UNHAPPY with the color of your teeth?	◯ Yes ◯ No		
Are you UNHAPPY with your smile? Why?	◯ Yes ◯ No	If yes	
How many times per day do you brush?			
Do you have an electric toothbrush that sits on a charger?	◯ Yes ◯ No		
How many times per week do you floss?			

Are your teeth sensitive to:

☐ Cold or sweet ☐ Hot ☐ Biting

Have you had a serious/difficult problem with any previous dental work? Please explain.	◯ Yes ◯ No	If yes	
Have you lost teeth due to disease?	◯ Yes ◯ No		
Have you ever had a bad dental experience? Please explain.	◯ Yes ◯ No	If yes	
When was your last dental visit (not cleaning)?			
When was your last dental cleaning?			

Why did you leave your previous dentist?

How can we accommodate you better during your dental visit?

What music, TV shows, or movies do you like?

Signature of Patient, Parent or Guardian:

X Date:_____

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Payment Term Options:

1. **Full Pay Cash Discount**: We offer a 5% accounting courtesy for all treatment that is paid in full (cash or check) at the time of service. We will still file your insurance and payment will go directly to you, the patient.
2. **Major Service: Two-Payment Option**: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.
3. **3rd Party Financing**: By arrangement with Care Credit or The Lending Club, we offer our patients, upon approval, an interest-free term loan (up to 12 months) or longer (interest may apply) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

Payments are expected at the time services are rendered. We accept cash, checks (under $500.00), debit cards, and all major credit cards.

Insurance Payments: We are happy to file your insurance claim for you. Copayment, Coinsurance, and/or Deductibles are due prior to treatment. Some insurance companies may choose to allow an alternate benefit for certain procedures. For example, a filling on a back tooth may not qualify for a tooth colored filling, only an amalgam (silver) filling which is reimbursed at a considerably lower amount. The same may apply to crowns and/or partials. We do our best to provide you with an accurate estimate of your portion.

*If for any reason the account is turned over for collection, an additional charge of 33 1/3% will be added to cover collection cost.

** A charge of $25.00 will be imposed for any bad check received by Randall Oaks Dental for any goods and services.

A finance charge of 2.5% will be charged monthly on balances over 30 days.

X

Patient/Guardian Signature Date

Cancelled/Missed Appointment Policy

At Randall Oaks Dental we are committed to providing you with quality care and excellent service. In order to do that we reserve specific appointment times for you. However, we understand that periodically situations may arise and appointments may need to be changed and/or cancelled. To best serve the needs of our patients and better utilize appointment times, we have instituted this policy.

Rescheduling an Appointment:

If it is necessary to reschedule your scheduled appointment, we require that you ***call at least 48 hours in advance.*** If you do not reach the office, please leave a detailed message on our voicemail. Please provide your name, phone number, and the date and time of the appointment you are seeking to reschedule. We would also appreciate you sharing the reason for rescheduling to determine if we can better meet the needs of our patients.

Missed Appointment Fee:

A ***charge of $50.00 will be assessed for all missed appointments.*** A missed appointment results when you do not attend a scheduled appointment, or you did not reschedule a scheduled appointment at least 48 hours in advance. A failure to present at the time of a scheduled appointment will be recorded in your record as a "no show" and the Missed Appointment Fee will be charged. The Missed Appointment Fee is not billable to your insurance and must be paid by you directly. Any exceptions to this policy will be reviewed on a case by case basis. We reserve the right to charge a $50.00 deposit for future appointments which will be applied to services rendered that day. This deposit is non-refundable in the event of a cancelled or rescheduled appointment.

By signing below, you are acknowledging that you have read, understood and agreed to these conditions.

X _____

Patient/Guardian Signature

X _____

Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Randall Oaks Dental
2261 Randall Rd
Carpentersville, IL 60110

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Randall Oaks Dental's *HIPAA Notice of Privacy Practices*.

I understand that Randall Oaks Dental's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Randall Oaks Dental's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Randall Oaks Dental's *HIPAA Notice of Privacy Practices*, I may contact Kimberly Smith at Randall Oaks Dental.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Randall Oaks Dental will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Randall Oaks Dental's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Kimberly Smith, noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
_____	_____
Persons authorized to discuss PHI	Relationship of Personal Representative

FOR OFFICE USE ONLY

Randall Oaks Dental made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Randall Oaks Dental was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID