

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

Allergies

Acrylic	<input type="radio"/> Yes <input type="radio"/> No	Dental Anesthetic	<input type="radio"/> Yes <input type="radio"/> No	Latex	<input type="radio"/> Yes <input type="radio"/> No	Penicillin/Amoxicillin	<input type="radio"/> Yes <input type="radio"/> No
Aspirin	<input type="radio"/> Yes <input type="radio"/> No	Erythromycin	<input type="radio"/> Yes <input type="radio"/> No	Metals	<input type="radio"/> Yes <input type="radio"/> No	Tetracycline	<input type="radio"/> Yes <input type="radio"/> No
Codeine	<input type="radio"/> Yes <input type="radio"/> No	Jewelry	<input type="radio"/> Yes <input type="radio"/> No				

Women: Are you...

Pregnant/Trying to get pregnant?	<input type="radio"/> Yes <input type="radio"/> No	Nursing?	<input type="radio"/> Yes <input type="radio"/> No	Taking oral contraceptives?	<input type="radio"/> Yes <input type="radio"/> No
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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.

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Patient/Guardian Signature

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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.**

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Patient/Guardian Signature

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Date

# ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

**Randall Oaks Dental**  
2261 Randall Rd  
Carpentersville, IL 60110

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 the Privacy Official at Randall Oaks Dental.

I understand that it is my right to refuse to sign this Acknowledgement should I 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 the Privacy Official, noted above, for assistance.

## 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

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date