2021

Name: _____ Birthdate: _____ Age: _____
Last First M.I.

Physician: _____ Physician's Phone: _____

Date of Last Appointment with Physician: _____ Date of Last Physical Exam: _____

Medical Conditions

Please circle any of the following that you have had or have at present:

Covid-19	Anemia	Thyroid Disease	Blood Transfusion
Heart Surgery	Stroke	X-Ray or Cobalt Treatment	Drug Addiction
Heart Failure/Disease/Attack	Kidney Trouble	Venereal disease (Syphilis, Gonorrhea)	Hemophilia
Angina Pectoris	Ulcers	Chemotherapy (cancer/Leukemia	Arthritis
Heart Pacemaker	Porphyria	Rheumatism	Cold Sores
Heart Murmur (Ailment)	Emphysema	Cortisone Medication	Genital Herpes
Rheumatic Fever	Cough	Glaucoma	Epilepsy or Seizures
Congenital Heart Defects	Tuberculosis (TB)	H.I.V.	Fainting or Dizzy Spells
Scarlet Fever	Asthma	Hepatitis A (Infectious)	Nervousness/Psychiatric Treatment
Artificial Heart Valve	G.E.R.D	Hepatitis B (Serum)	Hypoglycemia
Pain in Jaw Joints	Sinus Trouble	Hepatitis C	Sickle Cell Disease
High Blood Pressure	Allergies or Hives	Liver Disease	Bruise Easily
Artificial Joint (s) i.e. knee, hip	Diabetes	Yellow Jaundice	Stomach/Intestinal Disease

Do you have reason to believe that you may have any of the above conditions undiagnosed? Yes ☐ No ☐

Remarks: _____

Medical Questionnaire

	Circle One	
Are you having pain or discomfort at this time?	Yes	No
Have you been a patient in the hospital during the past two years?	Yes	No
Have you been under the care of a medical doctor during the past two years?	Yes	No
Have you had surgery to place Pins, Screws, Plates, etc.?	Yes	No
Have you been diagnosed with Sleep Apnea?	Yes	No
Have you had the Gardasil (HPV) Vaccine?	Yes	No
Have you ever had any excessive bleeding requiring special treatment?	Yes	No
Has your medical doctor ever said you have cancer or a tumor?	Yes	No
Have you ever had radiation therapy?	Yes	No
When you walk upstairs or take a walk, do you ever have to stop because of Pain in your chest, shortness of breath or because you are very tired?	Yes	No
Have you lost or gained more than ten pounds in the past year?	Yes	No
Do you ever wake up from sleep short of breath?	Yes	No
Are you on a special diet?	Yes	No
Do you have any disease, condition or problem not listed?	Yes	No
WOMEN: Are you pregnant now?	Yes	No
Are you practicing birth control?	Yes	No
Do you anticipate becoming pregnant?	Yes	No

Dental Questionnaire

1. Have you ever had: (Please Check)

a. Orthodontic Treatment	☐	e. Brushing & Flossing Instructions	☐
b. Periodontal Treatment	☐	f. Novocaine or other Local Anesthetic	☐
c. Tooth Extraction	☐	g. Nitrous Oxide gas	☐
d. Other Dental Surgery		h. A bad experience in a dental office.	☐

2. When were your last X-rays taken? _____ By whom? _____
3. How often do you brush? _____ Floss? _____
4. How often do you replace your toothbrush? _____

5. Are you experiencing any discomfort in your mouth right now?	Yes	No
6. Do you ever experience any sensitivity in your mouth?	Yes	No
7. Do you have a habit of grinding or clenching your teeth?	Yes	No
8. Do you ever hear a clicking or popping noise when you chew?	Yes	No
9. Do your gums ever bleed?	Yes	No

10. Do you have any dental concerns at this time? _____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change I will inform the doctor of dentistry at my next appointment without fail.

_____ _____
Date *Signature of Patient, Parent or Guardian*

Medication

Please check any medications you are currently On or have taken within the last two years.

_____ Analgesic (Aspirin, Ibuprofen)
_____ Birth Control Pills
_____ Tranquilizers
_____ Blood Thinners
_____ Hypertension Drugs (Blood Pressure)
_____ Antihistamine (Allergy/Cold Drugs)
_____ Heart Drugs
_____ Antibiotics (Penicillin, etc.)
_____ Water Pills (Diuretics)
_____ Vitamins/Supplements
_____ Tobacco Usage (any type)

Other Medications:

_____

_____

Allergies

Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by:

_____ Penicillin
_____ Sulfa
_____ Novocaine (or other Caine Drugs)
_____ Latex Allergy
_____ Eggs
_____ Bee stings
_____ Dust
_____ Pollen
_____ Other: (Please indicate)

Remarks: _____

_____

_____

PLEASE COMPLETE OPPOSITE SIDE

Smiles by Design Group, Ltd.

Medical/Dental History

2021

Registration

Smiles By Design Group, LTD

Patient's Name: _____ Date: _____ Birthdate: _____

Last First M.I.

How do you wish to be addressed: _____ Patient's S.S. #:_____

Single: ___ - Married: ___ - Divorced: ___ - Separated: ___ - Widowed: ___

Mailing Address: _____ City, State, Zip: _____

Physical Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Employer: _____ Business Phone: _____

Employer Address: _____

Person Responsible for Account: _____

Dental Insurance: Primary

Employee Name: _____ Birthdate: _____

Employer: _____ Number of years:_____

Insurance Company: _____ I.D./SS#: _____

Policy / Group #: _____ Union Local: _____

Dental Insurance: Secondary

Employee Name: _____ Birthdate: _____

Employer: _____ Number of years:_____

Insurance Company: _____ I.D./SS#: _____

Policy / Group #: _____ Union Local: _____

Reason for Visit:

Examination: _____ Consultation: _____ Cleaning: _____ Happy Visit: _____

Emergency: _____

Whom may we thank for this referral? _____

Number of family members in household: _____

Name:	Age:	Sex:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE COMPLETE OPPOSITE SIDE.

Preferences: Novacaine: _____ N_2O (gas): _____

SMILES By Design Group, Ltd.
10015 Main Street · P.O. Box 532 · Richmond, IL 60071 · (815)678-4551 ph · (815)678-4555 fax

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barrriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by _____ (insert name of Practice) and/or its staff be handled in the following manner:

- For written communications: Address to: _____

  _____

  _____

  _____

- For oral communications: Call: _____

  (telephone number)

  May we leave a message?

  Yes ☐ No ☐

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:

_____

_____

_____

_____
Patient Signature

_____
Date

For Practice Use Only

Practice:	☐ Accepts ☐ Denies
Privacy Officer Signature:	_____
Date:	_____

Financial Policy

Thank you for choosing Smiles By Design Group, Ltd. As your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, credit cards. Outside financing is available upon request and approval.

Please check if you would like more information about financing options _____

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 40%. If balance is past due 30days or more a 1.5% monthly finance charge will be assessed.

Do you have insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine that amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance policy. Our office is not a party to that contract.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card at the time we provide the service to you.

- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 day, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Consent:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids 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 indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature (Parent of Child)_____ Date_____