WELCOME

We, at Advanced Laser & Cosmetic Dentistry and Advanced Family Dental Spa, are proud to be part of a team whose primary mission is to delivery the most up to date and comprehensive care to our patients. We feel a clear understanding of our office policies is important in developing a professional relationship.

INSURANCE

As a courtesy, we will file your dental claims for you. We participate with many insurance plans, but please inquire if we accept your insurance to avoid billing problems later. We will give you the best **ESTIMATE** of any out of pocket expenses prior to your appointment, but this is only an estimate. Your insurance company will determine your final benefits at the time the claim is processed. You are responsible for any charges your plan does not cover.

PLEASE INITIAL_____

APPOINTMENTS & CANCELATIONS

We feel our patient's time is valuable. When your appointment is made: a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment, you can expect us to be prompt.

When we schedule your appointment, we are reserving a room for your specific needs. We ask that in the event you need to change an appointment, **48 hours notice** is given.

Appointments canceled less than 48 hours in advanced, not showing up for a scheduled appointment or tardiness past 15 minutes are considered broken appointments. Cancellations and/or missed appointments will result in an office visit charge. We understand emergencies arise, but please be courteous and notify us.

PLEASE INITIAL _____

I understand and agree that, regardless of my insurance (if applicable), I am ultimately responsible for the balance on my account for all charged and services rendered. I have read all the information on this sheet.

I have read and understand the above policies

Patient Name (printed):_____Date:_____

Patient/Guardian Signature:_____Date:_____

Advanced Laser & Cosmetic Dentistry, LLC
720 Cog Circle, Suite H
Crystal Lake, IL 60014
(779) 220-4396

Advanced Family Dental Spa, LLC
2429 Randall Road, Suite A
Carpentersville, IL 60110
(847) 844-0268

Patient Information

First Name_____ **Last Name**_____

Preferred Name_____ ☐ **Male** ☐ **Female**

Address_____

City_____ **State**_____ **Zip**_____

Social Security. #_____ **Date of Birth**_____

Home Phone_____ **Cell Phone**_____

Work Phone_____ **Email**_____

Emergency Contact (Name/Number)_____**Relationship to patient**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Domestic Partner**

How did you hear about our office: ☐ **Mailer** ☐ **Location** ☐ **Other** _____

What is the best way to confirm appointments? ☐ **Text** ☐ **Email** ☐ **Phone Call** ☐ **Other**_____

Primary Insurance

Subscriber Name_____ **Relationship to Patient**_____

Subscriber Date of Birth_____ **Subscriber ID#**_____ **Group#**_____

Subscriber Employer_____

Insurance Company Name_____ **Insurance Phone #**_____

Insurance Company Address_____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Advanced Laser & Cosmetic Dentistry, LLC and/or Advanced Family Dental Spa, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____ **Date**_____

Relationship to Patient_____

Medical History

Do you have a primary physician? ☐ Yes ☐ No If yes, date of last visit_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Physician Name_____ Physician Phone #_____

Are you currently taking any prescription and/or over the counter medication? ☐ Yes ☐ No

If yea, please list each one (or you may provide us with a list)_____

_____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain_____

Have you ever had any rods, pins or implants placed? ☐ Yes ☐ No

Have you ever had any of the following?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial joints/valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenial Hearth Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV/AIDS
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Metal
Y N Penicillin
Y N Sulfa Drugs

Other_____

Dental History

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor Do your gums bleed? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in any pain? ☐ Yes ☐ No If yes, explain_____

How many times a day do you: Floss_____ Brush _____ Type of Bristles: ☐ Soft ☐ Medium ☐ Hard

Have you lost any adult teeth (NOT for Orthodontic reasons)? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No If yes, explain_____

When was your last dental cleaning? _____

Why did you leave your previous dentist? _____

HIPAA

Acknowledgement of receipt and general consent.

I acknowledge that I received a copy of the notice of the Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances describes in the Notice of Privacy Practices.

Patient Name_____Date_____

Signature_____

Relationship to patient_____

*******FOR PATIENTS WHO ARE 18 YEARS OF AGE AND OLDER*******

I give my permission to those listed below to have access to my dental information and to discuss matters relating to my care. I recognize that if I do not list anyone below, I am the only person who will have access to information regarding my dental information and care.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient Name_____Date_____

Signature_____