Medical History

When was your last physical exam? _____ Last blood test?_____
Have you been under a care of a medical doctor in the past two years? Yes or No
If yes, for what condition? _____
Physician's name: _____ Phone # _____
Have you taken any prescription medications during the past two years? Yes or No
If yes, please list the medications:

_____

Prescription medications now taking: Please give name, dosage and for what condition:

_____

Are you allergic to any medications or substances that cause adverse reactions to you? Yes or No
If yes, please list medications:

_____

Have you been hospitalized or had an operation within the past five years? Yes or No
If yes, what was it for?

_____

Do you have or ever had any of the following?

Heart (surgery, disease, attack, stroke)	yes no	Asthma	yes no
Chest pains	yes no	Hay fever	yes no
Congenital heart disease.....	yes no	Latex sensitivity	yes no
Heart murmur	yes no	Allergies or hives	yes no
High or Low blood pressure	yes no	Sinus trouble	yes no
Mitral valve prolapse	yes no	Radiation therapy	yes no
Artificial heart valves	yes no	Chemotherapy	yes no
Heart pacemaker	yes no	Tumors	yes no
Rheumatic fever	yes no	Hepatitis A or B	yes no
Arthritis or/and rheumatism	yes no	Tuberculosis	yes no
Steroid usage (internally and/or externally) ..	yes no	A.I.D.S.	yes no
Swollen ankles	yes no	H.I.V. positive	yes no
Artificial joints (hips, knees, etc.)	yes no	Blood transfusions	yes no
Kidney trouble	yes no	Hemophilia	yes no
Ulcers (internally and externally)	yes no	Sickle cell disease	yes no
Diabetes	yes no	Liver disease	yes no
Thyroid problems (hyper or hypo)	yes no	HPV(human papilloma virus)…..	yes no
Glaucoma	yes no	Neurological Disorders....	yes no
Contact lenses	yes no	Epilepsy or seizures	yes no
Emphysema	yes no	Fainting or dizzy spells	yes no
Lasik Surgery	yes no	Cancer	yes no
Chronic cough	yes no	Nervous/anxiety attacks	yes no
Psychiatric/psychological care	yes no	Cold Sores……	yes no

Have you lost or gained 10 pounds or more in the past year? Yes or No
Are you experiencing excessive stress or pressure at your work or at home? Yes or No
Do you have or have you had any disease, condition, or problem not listed above? Yes or No
If yes, please list:

_____

For Women: Are you pregnant? Yes or No Are you nursing? Yes or No
If yes, how many months? _____ Are you taking birth control? Yes or No

DENTAL HISTORY

So that we may provide you with the best possible care, please fully complete both sides of this form. All information will
be kept completely confidential.

Name _____ Date _____

What is the reason for your visit today?_____

Date of last dental visit _____ Last dental cleaning _____

What was done at the last dental visit?

_____

How often do you have dental examinations?

_____

How often do you brush daily? 1x 2x 3x 4x

How often do you floss: 1x/day 2x/day 3x/day 1x/week 1x/month

What other dental aids do you use? Night Guard Toothpicks Electric Toothbrush Floss Mouth Washes

Do you have any discomfort at this time? Yes No
If yes, please describe:

_____

Have you had an upsetting dental experience? Yes No
If yes, please describe:

_____

Does dental treatment make you nervous? Yes No slightly moderately extremely
Are you satisfied with the appearance of your teeth? Yes No
If no, how would you like to improve the appearance of your teeth?

_____

Do you have any of the following?

Mouth			Teeth		
Bleeding and/or sore gums	yes	no	Loose teeth	yes	no
Unpleasant taste and/or bad breath ..	yes	no	Sensitive to hot/cold	yes	no
Frequent cold sores or blisters	yes	no	Sensitive to sweets	yes	no
Swelling or lumps	yes	no	Sensitive to biting	yes	no
Orthodontic treatment	yes	no	Food impaction	yes	no
Biting cheeks or lips	yes	no	Clenching or grinding	yes	no
Clicking or popping jaw	yes	no	Change or shifting bite	yes	no
Difficulty opening or closing jaw	yes	no	Smoke or chew tobacco...	yes	no

Is there anything else about having dental treatment you would like us to know? Yes no
If yes, please describe:

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission of the respective health care provider or agency to release such information to your office. As a patient of Chicago Smiles, I will notify the staff of any changes in my health or the medications I am taking.

Patient or Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

CHICAGO | SMILES

In order to provide you with the best treatment and keep the cost of that treatment reasonable, we ask that you review our financial policy. We require that you read and initial the following statements.

_____Your portions for services rendered are due at the time of service. Patients with insurance are required to pay the deductible (if applicable) and estimated co-payment or portions at the time of service. We are more than happy to assist you with the filing of your insurance, however, keep in mind that the co- pay/patient portion amount is an ESTIMATE. You are responsible for any account balance that is not paid by your insurance company.

_____ Our policy is that we require your insurance to pay on claims in 60 days. Most insurance companies pay in45 days. I authorize payment of the dental benefits, otherwise payable to me, directly to Chicago Smiles, LLC. If your claim becomes outstanding by 60 days you will be notified on your next statement and the full balance will be due by you. We will no longer bill secondary insurance claims.

_____ If your treatment requires two or more visits to our office (i.e. crowns, implants, veneers, bridges, partials or dentures), your balance for the estimated patient portions will be due on the first day of treatment or the "prep date" unless payment arrangements have been made prior to the start of treatment. A deposit will be needed to hold long appointments with the Doctor.

_____ We only accept payment in the forms of Cash, Check, Visa, MasterCard, or AMEX. We do accept HSA cards or flex cards.

_____ We request that in the need to cancel an appointment, you give us at least 48 hours notice. If 48 hours notice is not given, a fee of $50.00 per hour of time with a Dental Hygienist or $75.00 per hour with the doctor will be considered and charged to your account. A deposit may be required to hold an appointment with the hygienist or the dentist.

_____ A late charge of $10.00 per billing cycle will be imposed on balances not paid in full within 30 days of your first statement. The fee for returned checks is $30.00. You are responsible for any unpaid balance to the office and any legal fees to collect such debt.

_____ Our office utilizes mercury-free (tooth colored) fillings and tooth colored crowns. Please be aware that some insurance will down grade the price of tooth colored (composite resin) fillings and crowns to the silver(amalgam) filling or gold crown price. You will be responsible for the difference.

_____ If you will be using dental insurance, it is your responsibility to verify active coverage of your PPO Dental Plan and to have working knowledge of it *prior* to your appointment. This information can be obtained through your HR department for group plans or the customer service phone number on the back of the card for individual plans. **Dr. Mark Santucci does not participate in Health Management Organizations (HMO or DMO); however, we do accept all PPO and Indemnity dental plans.** We will submit all claims to your insurance company on your behalf. If you have an HMO or DMO and decide to keep your appointment, you will be repsonsible for payment of all services performed the day of the appointment. New patient visits can range from $80.00- $320.00 depending on services rendered that day.

I have read, understand and agree to the above policy. I understand that I am fully responsible for the fees of service rendered, regardless of any insurance that I may have.

_____ _____/_____/_____

Patient/Responsible Party Signature Date