ARDEN
DENTAL CENTER

531 E. Roosevelt Road• Suite 100• Wheaton, IL 60187• 630-529-0303

PATIENT INFORMATION

Full Name _____ SS#_____ Date of Birth_____

Address_____ City _____ State/Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer_____ Email Address_____

Please Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Whom may we thank for referring you? _____

Who should we contact in case of Emergency? Name_____

Emergency contact phone #_____ Relationship to Patient_____

RESPONSIBLE PARTY

Name of Person financially responsible for this account _____

Relationship to Patient_____ Address _____

SS#_____ Date of birth_____ Home Phone _____

Cell Phone _____ Work Phone _____ Is this person currently a patient in our practice? ☐YES ☐ NO

Employer Name _____ Email Address _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Name of Policy Holder_____ Relationship to Patient _____

Member ID#/SS#_____ Date of Birth (Policy Holder) _____

Name of Employer _____ Work Phone ( ) _____

Insurance Company _____ Group #_____ Union or Local# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance

Name of Policy Holder_____ Relationship to Patient _____

Member ID#/SS#_____ Date of Birth (Policy Holder) _____

Name of Employer _____ Work Phone ( ) _____

Insurance Company _____ Group #_____ Union or Local# _____

Insurance Co. address _____ City _____ State _____ Zip _____

AUTHORIZATION AND RELEASE

I hereby authorize Arden Dental P.C. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request payment of the dental insurance benefits otherwise payable to me directly to Arden Dental P.C. I understand that I am financially responsible for all charges whether or not paid by the insurance. If my dental insurance pays less than expected, I understand any remaining balance is my responsibility and I agree to be responsible for payment on all services rendered on my behalf and my dependents. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance. I understand payment is expected at the time of service. Please note: Returned checks will be subject to additional fees. If Arden Dental P.C. seeks enforcement of payment through the services of a collection agency, I shall be responsible for any incidental expenses, including collection costs/attorney fees.

Patient Signature _____ **Date**_____ Reviewed By _____

(If patient is a minor, a parent or guardian must sign) (Staff Signature)

PATIENT DENTAL HISTORY

Please check any that apply to you:	YES	NO
Sensitivity (hot, cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
Headaches, ear aches, neck pain	☐	☐
Jaw joint pain	☐	☐
Teeth or fillings breaking	☐	☐
Bleeding, swollen or irritated gums	☐	☐
Grinding or clenching teeth	☐	☐
Loose, tipped or shifting teeth	☐	☐
Bad breath	☐	☐
Do you have or have you ever had any of the following?		
Dentures or partials	☐	☐
Braces/Orthodontic treatment	☐	☐
Facial Aesthetics (Botox or Juvederm)	☐	☐
Periodontal/Gum Disease	☐	☐

	YES	NO
If you could whiten your teeth for an affordable cost, would you do it?	☐	☐
Would you like to replace old silver fillings to tooth colored fillings?	☐	☐
Would you like to straighten your teeth?	☐	☐
Rate your smile on a scale from 1 to 10 _____		
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
If yes, what _____		
Do you smoke or chew tobacco?	☐	☐
How often? _____pack(s)/day		
Do you have dry mouth?	☐	☐
Have you ever had trouble getting numb?	☐	☐
Are you fearful of dental treatment?	☐	☐

When was your last cleaning? _____/_____ Your last complete x-rays _____/_____
Name of previous dentist _____City _____ State _____ Phone _____
Why did you leave your previous dentist ? _____

PATIENT MEDICAL HISTORY

Primary Physician Name _____ Office Phone _____ Last Exam _____

	YES	NO
Have you ever been hospitalized for any surgical operation or serious illness in the past 5 years?	☐	☐
If yes, please explain _____		
Are you taking any medication(s) including non -prescription?	☐	☐
If yes, what medication(s) are you taking? _____		

	YES	NO
Women ONLY		
Are you/do you think you are pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐

Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High blood pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker/Defib	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement/Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Sleep Apnea	☐	☐

BP_____ Glucose Level_____ Cholesterol Level_____ Other: _____

ALLERGIES Are you allergic to any of the following?

☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Aspirin ☐ Latex ☐ Valium ☐ Local Anesthetic ☐ Iodine ☐ Tetracycline ☐ Codeine

Other allergies (Please List) _____

CONSENT

The undersigned herby 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 be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

I agree to have my pictures/video taken and released on the Arden Dental Center website or social media. Yes ☐ No ☐

_____ _____ _____

Patient Signature **Date** **Dentist Signature**

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Acknowledgment of Receipt of Privacy Practices Notice & Communication Preferences

Section A: The Patient

Name:_____
Address:_____
Telephone:_____E-Mail:_____

Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from Arden Dental.

I give Arden Dental permission to speak to the following regarding:

	Appointments	Treatment	Bills
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section C: Cell Phone Consent

I, _____, consent to the dental practice using my cell phone regarding appointments, treatments, and my account. I understand that I can withdraw my consent at any time.

- ☐ call
- ☐ text

Signature_____ Date:_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representatives Name:_____
Relationship to individual: _____

Signature: I attest that the above information is correct

Signature: _____ Date:_____

Print name: _____ Title: _____

FOR OFFICE PERSONNELL ONLY
Section C: Good Faith Effort to Obtain Acknowledgement of Receipt.
Describe your good faith effort to obtain the individual's signature on this form:
_____
_____
_____
Describe the reason why the individual would not sign this form: _____
_____
_____

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Financial Relationship

Thank you for choosing Arden Dental PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for all patients by offering several payment options.

You may choose one of the following:

- Cash, Check, American Express, Visa®, MasterCard®, or Discover Card®

- In-House Financing (up to 3 months)

- Convenient Monthly Payment Options[1] from **CareCredit** Healthcare Credit Card
  - Allows you to pay over time
  - No annual fees or pre-payment penalties
  - 0% interest if paid in full within 6 months

Please note:

Arden Dental PC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, our office is committed to helping patients maximize their benefits. Insurance policies vary greatly and we can only **estimate** your coverage in good faith, but cannot guarantee coverage due to the complexities of these contracts. Our fees reflect the time that our doctor spends with each patient, the materials used as well as the overall quality of care and service that we provide in our practice. In order to maintain Arden Dental's level of excellence, **your estimated patient portion will be due at the time of treatment.** As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. If a procedure is not covered for any reason by my insurance, I, the patient will make the payment of my balance in full.

Arden Dental PC charges for returned checks.

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. A fee of $60.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print) Date