PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. PATIENTS LAST NAME_____
2. PATIENTS FIRST NAME_____
3. SEX_____
4. BIRTHDAY MM/DD/YY_____
5. SSN_____
6. STREET ADDRESS_____
7. CITY, STATE_____
8. ZIPCODE_____
9. HOME PHONE_____
10. CELL PHONE_____
11. EMAIL ADDRESS_____

FINANCIALLY RESPONSIBLE PERSON (IF NOT YOURSELF)

1. LAST NAME_____
2. FIRST NAME_____
3. BIRTHDAY MM/DD/YY_____
4. SEX _____
5. SSN_____
6. STREET ADDRESS_____
7. CITY, STATE_____
8. ZIPCODE_____
9. HOME PHONE_____
10. CELLPHONE_____
11. EMAIL ADDRESS_____

COMPLETE THE FOLLOWING IF YOU HAVE DENTAL INSURANCE

1. EMPLOYER OR COLLEGE_____
2. EMPLOYERS OR COLLEGE ADDRESS_____
3. WORK PHONE_____
4. INSURANCE COMPANY_____
5. INSURANCE COMPANY PHONE_____
6. GROUP NUMBER_____
7. LOCAL UNION NUMBER(IF ANY)_____
8. EMPLOYEE I.D. # IF DIFFERENT THAN SS#_____
9. SECOND INSURANCE COMPANY (IF ANY)_____

How will you be paying for services?

_____Cash _____Check

_____MasterCard/Visa/Discover _____Insurance consignment

Persons paying by check, insurance or M/C/Visa/Discover will be required to present I.D

REFERRED BY: _____

Would like to be contacted for recalls by ____Mail _____Email

_____Text(Please put carrier_____)Example AT&T, Sprint, Verizon…..Etc

Park Avenue Dental **MEDICAL AND DENTAL HISTORY**

Today's Date____/____/____ Date of Birth____/____/____

Name_____ YES NO

1. Are you in good health? ____ ____
2. Has there been any change in your general health within the past year? ____ ____
3. Date of last physical examination _____
4. Are you now under the care of a physician or health care professional? ____ ____
5. If so, what is the condition being treated? _____
6. Name and address of physician_____

   _____Phone No._____
7. Have you had any serious illness, operation, or been hospitalized in the past five years? ____ ____
8. If so, what was the problem? _____
9. FEMALES ONLY: Are you pregnant? Y or N Do you take oral contraceptives? Y or N
10. CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

SKIN
__Itching
__Rash/hives
__Ulcers
__Shingles
__Pigmentation/skin color changes
__Lack or loss of body hair
__Other

EYES/EARS/NOSE/THROAT
__Visual change/blurring
__Glaucoma
__Loss of hearing
__Ringing in ears
__Frequent ear infections
__Frequent nose bleeds
__Sinus problems
__Frequent sore throat/hoarseness
__Other

HEART/BLOOD VESSELS
__Rheumatic fever
__Heart murmur
__Chest pain
__Heart attack
__Stroke
__Shortness of breath
__Swelling of ankles
__High/low blood pressure
__Congenital heart disease
__Prosthetic valves
__Heart surgery
__Pacemaker
__Vascular diseases
__Anemia
__Other_____

BONE/MUSCLES/JOINTS
__Bone deformity/fracture
__Arthritis/rheumatism
__Artificial joint
__Muscle weakness/pain
__Osteoporosis/Osteopenia
__Other

DIGESTIVE SYSTEM
__Hepatitis/Liver disease
__Jaundice
__Ulcers
__Change in appetite
__Black or bloody stools
__Other_____

GENITOURINARY
__Kidney disease
__Kidney transplant/dialysis
__Difficulty/pain on urination
__Blood in urine
__Frequent urination
__Sexually transmitted disease
__Prostate trouble
__Other

BLOOD/LYMPH/IMMUNE
__Easy bruising/excessive bleeding
__Persistent swollen glands
__Blood transfusion
__Hemophilia
__Anemia/sickle cell
__HIV positive/AIDS
__Leukemia
__Spleen problems

GENERAL
__Autoimmune disease
__Weakness/Tire easily
__Night sweats
__Persistent fever

NERVOUS SYSTEM
__Frequent headaches
__Dizziness/fainting
__Epilepsy/seizures/convulsions
__Neuritis/neuralgia
__Parasthesias/numbness/tingling
__Paralysis
__Hydrocephalic shunt
__Other_____

PSYCHIATRIC
__Nervousness
__Irritability
__Depression/excessive worry
__Mental illness
__Other_____

ENDOCRINE (GLANDS)
__Diabetes
__Thyroid trouble/goiter
__Weight change
__Excessive thirst
__Other_____

RESPIRATORY
__Tuberculosis
__Emphysema/bronchitis
__Asthma/wheezing
__Persistent cough
__Other_____

OTHER
__Radiation therapy
__Chemotherapy
__Tumors or growth
__Cancer
__Alcohol use
__Tobacco use
__Chemical dependency
__Vaping
__Marijuana

OVER →

Park Avenue Dental Care

MEDICAL AND DENTAL HISTORY

(Continued)

11. Are you allergic or have experienced any reaction to the following?

__Local anesthetics (e.g., novocaine)
__Penicillin/other antibiotics
__Sulfa drugs
__Barbiturates/sedatives/sleeping pills
__Iodine
__Latex or rubber gloves/dam
__Metals
__Aspirin
__Codeine or other narcotics
__Other_____

12. Do you take any of the following?

__Antibiotics/sulfa drugs
__Blood thinners
__Aspirin
__Blood pressure medication
__Antineoplastics
__Digitalis/other heart drugs
__Nitroglycerin
__Insulin/other diabetes drugs
__Cortisone/steroids
__Medication for thinning bone
__Thyroid medicine
__Antihistamines/allergy medications
__Recreational drugs
__Other medication_____

If yes to any of the above, list name of medication and dosage below:

_____

_____

13. Do you have any disease, condition, or problem not listed above that you should tell the dentist? If so, please explain_____

_____

_____

14. Do you have or have you ever had any of the following?

__Dental pain
__Bleeding gums/periodontal disease
__Blisters/ulcers/cold sores
__Swelling/lumps in mouth
__White coating on tongue/throat
__Problem with tonsils/adenoids
__Clicking/popping jaw
__Difficulty opening/closing jaw
__Pain in or near ears
__Sinus trouble
__Injury to face/jaw
__Surgery to face/jaw
__Loose teeth
__Sensitive teeth
__Clenching/grinding jaw
__Shifting of teeth
__Dissatisfied with appearance of teeth
__Ortho treatments (braces)
__Do you wear dentures or partials

15. Does dental treatment make you nervous? ___Yes ___No

16. Have you had difficulties with past dental treatment? ___Yes ___No

Please explain_____

17. Last dental visit?_____ Were x-rays taken? Y or N

I certify that I have read and understand the above. _____
Signature of patient/Date

FOR COMPLETION BY THE DENTIST

Comments: _____

_____

_____

_____

_____

_____

_____

Dental management considerations: _____

_____

Is medical consultation necessary? __Yes __No

_____

Signature of dentist/Date

James J. Kreuz, DDS ❖ Gregory J. Duffner, DDS ❖ Judy A. Johnson, DDS ❖ Rebecca J. Hudson, DMD
18040 Park Avenue, Homewood, IL 60430 ❖ Phone: (708) 798-6868

Financial Policy

Insurance Benefits: We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between **you and your insurance company. We ask that you read your policy carefully.** Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payment level that is quoted nor have information on any benefits possibly used in another dental office within the plan year. Any balances remaining after your insurance pays are due within 30 days of billing.
Please note: We accept all PPO insurances; however, we are considered out-of-network for most plans.

Missed Appointments: For the courtesy of other patients that are waiting for appointment times, please be aware that we require 48 hours notice to change or cancel an appointment. Failed appointments are subject to a $100 charge.

Payment Options: We accept: all major credit cards, Care Credit, cash or checks.

Payment Plans: For balances over $1,500, we can set up a payment plan where your balance is divided over several months. Ask our front desk team for more information.

Consent For Care

I request the consultation services of Park Avenue Dental Care. I authorize the doctor to take any necessary x-rays, study models, photographs, or diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of treatment needs.

Printed Name: _____ Date: _____

Patient's Signature: _____

HIPAA Consent Form

HIPAA stands for the Health Insurance Portability and Accountability Act. As stated by the CDC, HIPAA is a federal law created in 1996 "to create a national standard for protecting sensitive patient health information from being disclosed without the patient's consent or knowledge."

At Park Avenue Dental Care, we take special care in protecting your health information. However, there are certain circumstances in which we must communicate with other healthcare providers and insurance companies. With your consent, you allow us to disclose necessary information to your health- and dental-care providers as well as your insurance company in order to provide the highest quality treatment for you.

At any point, you have the right to rescind your consent in a written letter, signed and dated by you. However, this repeal shall not affect any disclosures made prior to your revocation, following any former approval. In communicating patient-specific information, we

As a patient, you understand:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- You have the right to restrict use of your information.
- You may revoke this Consent in writing at any time and all future disclosures will cease.
- Park Avenue Dental Care may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form; therefore, same-day-of-service payment in full for any services will be required.

Patient Name (printed): _____

Signature of patient or guardian: _____

Date: _____ Relationship to patient (if other than patient): _____

Signature of practice representative: _____