PlumGrove
DENTAL CENTER
Est. 1954

ABOUT YOU

Today's Date: ____________________

Name: ____________________ *I prefer to be called:* __________ ○*Male* ○*Female*
(Last) (First) (Middle)

Birth date: ____________________ *Social Security #:* __________

Marital Status: ○*Single* ○*Married* ○*Divorced* ○*Widowed* ○ *Separated*

Home Address: ____________________
Street City State Zip

Home Phone: __________ *Cell Phone:* __________ *Work Phone:* __________

E-Mail Address: ____________________ *Driver's License #:* __________

Who may we thank for referring you? ____________________

Who is responsible for payment on this account? ____________________

Relative not living with you

Name: __________ *Relation:* __________ *Home Phone:* __________
Address: ____________________
Street City State Zip

Spouse Information

Name: __________ *Birth date:* __________ *Social Security #:* __________

Insurance Information

Primary Insurance Name: __________ *Group # (Plan, Local or Policy #):* __________

Dental Coverage? ○*Yes* ○*No* *Orthodontic Coverage?* ○*Yes* ○*No*

Phone #: __________

Ins. Address: ____________________
Street / PO Box City State Zip

Insured's Name: __________ *Insured's Social Security #:* __________
Insured's Birth date: __________ *Insured's Employer:* __________
Insured's ID #: __________ *Relation:* __________

Secondary Insurance Name: __________ *Group # (Plan, Local or Policy #):* __________

Dental Coverage? ○*Yes* ○*No* *Orthodontic Coverage?* ○*Yes* ○*No*

Phone #: __________

Ins. Address: ____________________
Street / PO Box City State Zip

Insured's Name: __________ *Insured's Social Security #:* __________
Insured's Birth date: __________ *Insured's Employer:* __________
Insured's ID #: __________ *Relation:* __________

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

Signature: ______________________________ *Date:* __________

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MEDICAL HISTORY

PATIENT NAME: ______________________ *Birth Date:* ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	○ Yes	○ No	*If yes, please explain:* ____________
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	*If yes, please explain:* ____________
Have you ever had a serious head or neck injury?	○ Yes	○ No	*If yes, please explain:* ____________
Are you taking any medications, pills, or drugs?	○ Yes	○ No	*If yes, please list:* ____________
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	
Are you currently or have you taken bisphosphonates?	○ Yes	○ No	*If "yes" circle one: Actonel, Boniva, Didronel, Aredia, Zometa, other*
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No *Taking Oral Contraceptives?* ○ Yes ○ No *Nursing?* ○ Yes ○ No

Are you allergic to any of the following?
Aspirin ☐ *Penicillin* ☐ *Codeine* ☐ *Acrylic* ☐ *Metal* ☐ *Latex* ☐ *Local Anesthetics* ☐ *Other* ☐

If Yes, please explain:

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

Condition			Condition			Condition		
AIDS/HIV Positive	○ Yes	○ No	*Excessive Bleeding*	○ Yes	○ No	*Lung Disease*	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	*Excessive Thirst*	○ Yes	○ No	*Mitral Valve Prolapse*	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	*Fainting Spells/Dizziness*	○ Yes	○ No	*Pain in Jaw Joints*	○ Yes	○ No
Anemia	○ Yes	○ No	*Frequent Cough*	○ Yes	○ No	*Parathyroid Disease*	○ Yes	○ No
Angina	○ Yes	○ No	*Frequent Diarrhea*	○ Yes	○ No	*Psychiatric Care*	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No	*Frequent Headaches*	○ Yes	○ No	*Radiation Treatments*	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	*Genital Herpes*	○ Yes	○ No	*Recent Weight Loss*	○ Yes	○ No
Artificial Joint	○ Yes	○ No	*Glaucoma*	○ Yes	○ No	*Renal Dialysis*	○ Yes	○ No
Asthma	○ Yes	○ No	*Hay Fever*	○ Yes	○ No	*Rheumatic Fever*	○ Yes	○ No
Blood Disease	○ Yes	○ No	*Heart Attack/Failure*	○ Yes	○ No	*Rheumatism*	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	*Heart Murmur*	○ Yes	○ No	*Scarlet Fever*	○ Yes	○ No
Breathing Problem	○ Yes	○ No	*Heart Pace Maker*	○ Yes	○ No	*Shingles*	○ Yes	○ No
Bruise Easily	○ Yes	○ No	*Heart Trouble/Disease*	○ Yes	○ No	*Sickle Cell Disease*	○ Yes	○ No
Cancer	○ Yes	○ No	*Hemophilia*	○ Yes	○ No	*Sinus Trouble*	○ Yes	○ No
Chemotherapy	○ Yes	○ No	*Hepatitis A*	○ Yes	○ No	*Spina Bifida*	○ Yes	○ No
Chest Pains	○ Yes	○ No	*Hepatitis B or C*	○ Yes	○ No	*Stomach/Intestinal Disease*	○ Yes	○ No
Cold Sores/Fever Blisters	○ Yes	○ No	*Herpes*	○ Yes	○ No	*Stroke*	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No	*High Blood Pressure*	○ Yes	○ No	*Swelling of Limbs*	○ Yes	○ No
Convulsions	○ Yes	○ No	*Hives or Rash*	○ Yes	○ No	*Thyroid Disease*	○ Yes	○ No
Cortisone Medicine	○ Yes	○ No	*Hypoglycemia*	○ Yes	○ No	*Tonsillitis*	○ Yes	○ No
Diabetes	○ Yes	○ No	*Irregular Heartbeat*	○ Yes	○ No	*Tuberculosis*	○ Yes	○ No
Drug Addiction	○ Yes	○ No	*Kidney Problems*	○ Yes	○ No	*Tumors or Growths*	○ Yes	○ No
Easily Winded	○ Yes	○ No	*Leukemia*	○ Yes	○ No	*Ulcers*	○ Yes	○ No
Emphysema	○ Yes	○ No	*Liver Disease*	○ Yes	○ No	*Venereal Disease*	○ Yes	○ No
Epilepsy or Seizures	○ Yes	○ No	*Low Blood Pressure*	○ Yes	○ No	*Yellow Jaundice*	○ Yes	○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No *If yes, please explain:* ____________

Comments: ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: ______________________ *Date:* ____________

COMMUNICATION INFORMATION

Communication is a very important part of providing quality health care. We may contact you to provide appointment reminders, information about treatment, or other health related services. Please provide us with your contact information and preferred method of contact.

Patient Name: ______________________

Home Phone #: ______________________

Work Phone #: ______________________

Cell Phone #: ______________________

Email: ______________________

Which number do you prefer to be contacted at? *Home* *Work* *Cell* *Email* (please circle one)

Would you like to receive an appointment confirmation by Email? *Yes* *No* (please circle one)
(please remember to confirm the email)

Would you like to receive appointment reminders by Text Messaging? *Yes* *No* (please circle one)
(please remember to confirm the text message)

Name: ______________________
(please print)

Signature: ______________________ Date: ______________

** This information will not be shared with any one**

Plum Grove Dental Center
HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ___________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT/EMAILED TO OTHER ATTENDING DOCTOR(S)/FACILITIES IN THE FUTURE. IF ANOTHER PARTY RECEIVES THEM IN ERROR, I ABSOLVE PLUM GROVE DENTAL CENTER OF ANY AND ALL LIABILITY RELATING TO SUCH SUBMISSION OF SAID RECORDS.

____________________________________ ____________________________________
Patient Name Date

____
Signature (Guardian, if patient is under 18)

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

____

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

____
Signature of Privacy Officer

X-Ray Request Form

In an effort to save you the potential cost of additional x-rays, please sign the following x-ray transfer form.
You can mail or fax this form to your **previous dentist**.
Duplicate x-rays should be sent to us prior to your appointment.

Please send any recent (2 years) Panorex, Full Mouth or Bite-wing x-rays to:

Plum Grove Dental Center
222 N. Plum Grove Road
Palatine, IL 60067

847-359-4700
847-359-9977 (FAX)

X-rays in digital format (.jpg) preferred: Email: xrays@plumgrovedental.com

Previous Dentist: ____

Phone # or Fax # for Previous Dentist: ______________________________

Signed:______________________________/______________________________
(patient signature) (please print patient name)

Date: ___/___/______