PATIENT INFORMATION UPDATE

Date ______________ Patient ______________ Birthdate ______________

Have there been changes in your address, telephone numbers, insurance or employment since your last visit? ☐ Yes ☐ No

Please specify ______________

Special concerns for today's visit ______________

Cell#

MEDICAL HISTORY

Physician's Name ______________ Date of last visit ______________

Phone (______)__________ Pharmacy ______________ Phone (______)__________

Condition	Yes	No
AIDS	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type ________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet/Weight Loss	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumors or Growths	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

Have you ever had or been diagnosed with:

Condition	Yes	No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints, Screws, Pins, etc.	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe ______________

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe ______________

Women: Are you pregnant? ☐ Yes ☐ No

Due date ______________

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Medication	Yes	No
Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Are you allergic to:

Allergen	Yes	No
Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Other ______________

Please PRINT all medications now taking: ______________

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________ Signature of Patient, Parent, Guardian or Personal Representative ______________ Date

______________ Please print name of Patient, Parent, Guardian or Personal Representative ______________ Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to ______________ Date ______________

Results ______________

Signature ______________ Date ______________

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DENTAL INFORMATION RELEASE FORM (HIPAA)

Downtown Dental & Implants of Oswego, Inc.

60 Main St. Suite C   Oswego, IL 60543

Dr. Shalini Mohan, D.M.D

Patient Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Email Address: ______________________________

Can we send you promotional emails? YES or NO

Preferred method of contact/appointment confirmation (please check one):

- ☐ Call home phone
- ☐ Send me a text message
- ☐ Send me an email

If unable to reach me at preferred method, you may:

- ☐ Leave me a detailed message
- ☐ Leave me a message asking to return your phone call, no details may be left.

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me an claims information. This information may be released to:

- ☐ Spouse: ______________________________
- ☐ Child(ren): ______________________________
- ☐ Other: ______________________________
- ☐ DO NOT RELEASE MY INFORMATION TO ANYONE.

*THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

Patient Name (print): ______________________________ Date: ____________

Patient Signature: ______________________________ Date: ____________

Witness Name (print): ______________________________ Date: ____________

Witness Signature: ______________________________ Date: ____________

Downtown Dental & Implants of Oswego, INC.
FINANCIAL POLICY AGREEMENT

Thank you for choosing Downtown Dental & Implants of Oswego for your dental needs! We are committed to providing you with the highest quality, personal dental care, and appreciate your commitment to adhere to this **Financial Policy Agreement**. We require all of our patients to read, understand, and sign it prior to any non-emergent treatment or care.

Appointments:

We understand circumstances may arise that require you cancel your appointment. Cancellations and appointment changes must be made by calling our office during our normal business hours (8:00 a.m. to 5:00 p.m. Mon, Tues, Thurs, 8:00am-7:00pm Wed, and 8:00am-12:00pm Fri). All cancellations require a 48 hour advanced notice, and cannot be made by voice mail, text or E-mail. This is important. If appointment is failed/cancelled less than 48 hours in advance, you will be charged a $50.00 cancellation fee.

Treatment Plans:

Treatment recommendations are based on the advanced training and experience of the Doctor. A cost estimate will be provided. However, clinical observations during a procedure may alter the treatment plan, causing estimated costs to fluctuate. You are responsible for any change in treatment costs as well as any balance not paid by your insurance.

Insurance and Past Due Balances:

As a courtesy to you we will file claims on your behalf. ALL COPAYS WILL BE COLLECTED AT THE TIME OF SERVICE. In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card at **each** visit.

You are responsible for ensuring your information is correct and effective at the time of each service.

All past due balances are due and payable at time of service.

Insurance Coverage:

- Commercial/Indemnity Insurance: Your policy is a contract between you and your insurance company. Because we are not a party to that contract, your account balance is your responsibility whether your insurance pays or not. Take time to read your insurance policy, and be sure to know what your deductibles are.
- Self Pay or Self Filing: Patients who do not have insurance coverage, who are unable to provide us with valid insurance information or who wish to file their own insurance claims are responsible for paying at the time services are rendered.

Payments:

All co-payments and deductibles designated by your insurance company are your responsibility and are **due at time services are rendered.** Any account balances billed to you must be paid within **30** days.

We do provide in-office payment plans as well as accept Care Credit's INTEREST FREE PLAN. If you are interested, please contact www.CareCredit.com. In the event you disagree with a balance due, it is your responsibility to contact the office's billing department to discuss any discrepancies within **30** days of receiving your statement.

Methods of Payment:

We accept Cash, Checks, American Express, Discover, Visa, and Master Card. A $25 fee will be charged for checks returned for insufficient funds.

Past Due Accounts:

In the event you have an unpaid balance 90 days overdue, appropriate action will be taken to collect the past due amount, and you will be responsible for the following additional fees:

- 40% collection fee added to the unpaid balance if your account is turned over to a collection agency

I hereby authorize my insurance benefits be paid directly to Downtown Dental & Implants of Oswego, INC. I am financially responsible for non-covered services,
co-payments, coinsurance, and deductibles. I also authorize Downtown Dental & Implants of Oswego, INC. to release any information required for the processing of this claim and all future claims.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

______________________________ ______________
Print Patient's Name Date

______________________________ ______________
Signature of Patient or Guarantor Date