Date:_____

Dynamic
DENTAL GROUP

2102 W. Randolph Vandalia, IL 62471
618-283-4900
www.dynamicdentalil.com

Patient Information:

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male: ____ Female: ____ Married: ____ Single: ____ Minor: Y N

SS#:_____ Driver's License #:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #:_____ Work #:_____ Cell #:_____

E-Mail address: _____ Best way to contact you: _____

Employer: _____

Emergency Contact: _____ Phone #:_____

Other family members seen by us: _____

How did you hear about us? _____

If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information (If patient is a minor):

Name: _____ Relationship to patient: _____

Birth Date: _____ SS#:_____ Driver's License #:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #:_____Work#:_____ Cell#:_____

Dental Insurance Information (Primary):

Policyholder's Name: _____ Birth Date: _____ SS#:_____

Policyholder's Address:_____ Policyholder's Phone #: _____

Insurance Company: _____ Group #:_____

Employer: _____Policyholder's ID #:_____

Patient Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_____

Dental Insurance Information (Secondary):

Policyholder's Name: _____ Birth Date: _____ SS#:_____

Policyholder's Address:_____ Policyholder's Phone #: _____

Insurance Company: _____ Group #:_____

Employer: _____Policyholder's ID #:_____

Patient Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other____

Patient Name: _____

Do you like your smile? YES NO

What, if anything, would you change about your smile? _____

Why have you come to the dentist today? _____

Are you currently in pain? YES NO Do your gums bleed? YES NO How many times a day do you brush? _____

Do you now have or have you ever experienced pain/discomfort in you jaw (TMJ)? YES NO

Have you been clinically diagnosed with Sleep Apnea? YES NO If yes, do you use a CPAP machine? YES NO

Do you smoke or use chewing tobacco? YES NO If yes, how long? _____ How often? _____

Previous Dentist or Dental Office: _____ Date of last dental visit_____

Physician's Name: _____ Phone #:_____

WOMEN: Are you or could you be pregnant? Y N Are you nursing? Y N Taking Oral Contraceptives? Y N

Are you currently being treated for or have you ever been treated for any of the following? Please circle all that apply:

Hearing Impaired	Epilepsy/Seizures	Tuberculosis	Hepatitis	Low Blood Pressure
Heart Murmur	Diabetes	Liver Problems	HIV/AIDS	High Blood Pressure
Mitral Valve Prolapse	Glaucoma	Sinus/Breathing Problems	Blood Transfusion	Heart Attack
Stroke	Arthritis	Cancer/Chemo/Radiation	Drug/Alcohol Abuse	Kidney Problems
Any transplant	Frequent Headaches	Psychiatric Care	Pacemaker/Heart Surgery	Herpes/Fever Blisters
Congenital Heart Defect	Artificial Valve/Joint/Implant	Asthma/COPD/Emphysema	Abnormal Bleeding/Anemia	Hospitalized for any reason

Please list any medical condition not listed above: _____

Are you allergic to any of the following: PLEASE CIRCLE **YES or NO** FOR EACH ONE

Penicillin	Y N	Erythromycin	Y N	Tetracycline	Y N	Dental Anesthetics	Y N	Codeine	Y N	Sulfa	Y N
Ibuprofen	Y N	Tylenol	Y N	Aspirin	Y N	Jewelry/Metals	Y N	Latex	Y N		

Other_____

Please list all medications you are currently taking: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____**Date:**_____

Parent/Guardian Signature **if patient is a minor:** _____Date:_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

Providers Signature: _____**Date:**_____

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Vandalia, IL 62471

Financial Consent for Service:

As a condition of treatment by this office, *all financial arrangements must be made in advance.* The practice depends upon collection from patients for the cost incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.
All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.
Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. Any cost for treatment that insurance does not pay will be the patient's responsibility. *It is our office policy to collect patient's estimated portion at the time of service.*
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I also agree if my account becomes past due and is turned over for collection there will be a collection fee of 25% of the outstanding balance added for which I will be liable.
I have read and understand the above conditions of treatment and payment; I agree and give my consent for treatment.

Signature: _____ Date: _____

Video and Photography Release:

I hereby grant permission to the rights of my images that may be obtained by Dynamic Dental Group during the course of my treatment. I understand my photograph will never be obtained without my knowledge & consent. I understand my image may be used in various publications, public affairs releases, recruitment materials, internal communications, public relations, educational materials, advertising; including but not limited to, broadcast, print, and communication endeavors. By signing this release, I understand this permission signifies that photographic images of me may be electronically displayed via the internet via the Dynamic Dental Group web page, Facebook, Twitter, or other business affiliated social media sites. I waive any rights to royalties or other compensation arising or related to the use of my image. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to the bound thereby. I hereby release any and all claims against any person or organization utilizing this material for the purposes outlined above.

Signature: _____ Date: _____

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Vandalia, IL 62471

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____ _____ _____
Print Name Signature Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you, or your dependents, covered under the Privacy Act to people other than yourself.
I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
(Please Print Name) (Relationship)

_____
(Please Print Name) (Relationship)

_____
(Please Print Name) (Relationship)

Signature of Patient/Guardian _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)