*This is a fillable form. Please download and **TYPE** your information.

FITZPATRICK DENTAL

Patient Information

Name of Patient _____ *Preferred Name* _____ ☐ *M* ☐ *F*

Address _____ *City* _____ *State* _____ *Zip* _____

Home number _____ *Cell Phone* _____ *Work Phone* _____

Date of Birth _____ *SSN* _____

Email _____

Employer _____ *Occupation* _____

Insurance Information *(As a courtesy, our office can file insurance claims on your behalf.)*

☐ *I DO NOT have dental insurance. I will be paying by the following methods at the time of service:*

☐ *Cash* ☐ *Personal Check* ☐ *Credit Card* ☐ *Care Credit (Payment plan option)*

☐ *I DO have dental insurance. I will be paying for my portion of services rendered with the method above at the time of treatment, and my insurance company will be billed for their portion by Fitzpatrick Dental. My insurance information is provided below.*

**** The person with the earliest birth date in the calendar year is the primary insured ****

Primary *Insured's Name* _____ *Date of Birth* _____

SSN _____

Employer _____ *Work Phone* _____

Insurance Company _____ *Insurance Co. Phone* _____

Insurance Co. Address _____ *City* _____

State _____ *Zip* _____

Group or Plan Number _____ *Policy Number* _____

Secondary *Insured's Name* _____ *Date of Birth* _____

SSN _____

Employer _____ *Work Phone* _____

Insurance Company _____ *Insurance Co. Phone* _____

Insurance Co. Address _____ *City* _____

State _____ *Zip* _____

Group or Plan Number _____ *Policy Number* _____

708.422.6116 4560 W. 103RD ST., OAK LAWN, IL 60453 SMILE@FITZDENTAL.COM FITZDENTAL.COM

FITZPATRICK
DENTAL

Authorization and Release

I, the undersigned (legally responsible party), authorize all dental treatment to be rendered by the dentist and staff of Fitzpatrick Dental. I will keep the office informed of changes in my health, address, or financial information.

I authorize Fitzpatrick Dental to release my information including the diagnosis and records of any treatment or examination to third party payors. I authorize Fitzpatrick Dental to submit insurance claims on my behalf, and assign directly to Fitzpatrick Dental all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of signature on all my insurance submissions, whether manual or electronic.

I assume full financial responsibility for all fees of services rendered, regardless of the level of reimbursement by the insurance plan. I understand that treatment plans may change during treatment, and will be informed of the changes, but I am still responsible for payment.

I certify that I have accurately answered all of the questions asked to me to the best of my knowledge.

Signature X_____ *Date* _____

Signature of patient or parent/guardian of minor

FITZPATRICK DENTAL

Financial Policy

Thank you for choosing Fitzpatrick Dental as your dental health provider. We are committed to seeing that you receive the highest quality care in a great environment. The following is a statement of our financial and appointment policy, which we require you to red and sign prior to your treatment.

If you have dental insurance, we submit your claim for reimbursement at our office. However, we do require payment of your deductible and payment of your ESTIMATED portion (amount insurance will NOT cover) for services at the time of services rendered. Any overpayment made on the account will be promptly returned to you by our office. Any remaining balance will be billed to you. In the event that your insurance plans has not paid us within 45 days, you will be responsible for the balance, regardless of pending reimbursement.

This office is considered a non-preferred or out-of-network provider. The amount of dental benefits you receive is determined by your employer, your union, or your insurance company, not by this dental office. We cannot render treatment determined on the assumption that our fees will be paid by your insurance company, or that treatment is determined or dictated by your insurance plan coverage. Our usual, customary, and reasonable fees often times do not correspond to your insurance company's. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates. It is your responsibility to review your insurance policy and understand your specific benefits. The more you know about your specific plan, the better we can serve you.

We are here to help you and explain any insurance information you may not understand and assist you in the reimbursement process through communication with your insurance company. We will do everything that we can to help you receive your benefits (i.e. transmission of your insurance claim, sending radiographs, explanation of treatment letters, necessity and urgency letters, and telephone conversations to insurance companies to provide needed information) all at no cost to you.

Cancellation Policy

*We believe that the dental appointment represents a shared responsibility for both doctor and patient. In order to have quality dental care at an affordable cost, these appointments must be kept. As a courtesy, we will try to contact you to confirm all appointments. However, it is your personal responsibility to remember your scheduled appointments.

In the event that you need to change your scheduled appointment, our office requires 24 hour notification.

Thank you for understanding our cancellation and financial policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this financial and appointment policy.

Signature X_____ *Date* _____

Signature of patient or parent/guardian of minor

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FITZPATRICK DENTAL

Medical Information

Name of Patient _____ *Date of Birth* _____

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.

Are you under a physician's care now?
☐ *Yes* ☐ *No* *Explain* _____

Have you ever been hospitalized or had a major operation?
☐ *Yes* ☐ *No* *Explain* _____

Have you ever had a serious head or neck injury?
☐ *Yes* ☐ *No* *Explain* _____

Do you take, or have you taken, Phen-Fen or Redux?
☐ *Yes* ☐ *No* *Explain* _____

Are you pregnant?
☐ *Yes* ☐ *No*

Nursing?
☐ *Yes* ☐ *No*

Have you ever taken fosamax, bonita, actonel or any other medications containing bisphosphonates?
☐ *Yes* ☐ *No* *Explain* _____

Are you on a special diet?
☐ *Yes* ☐ *No* *Explain* _____

Do you use tobacco?
☐ *Yes* ☐ *No* *Explain* _____

Do you use controlled substances?
☐ *Yes* ☐ *No* *Explain* _____

Are you taking any medications, pills, oral contraceptives or drugs?

Please list: _____

_____

_____

Are you allergic to any of the following?

☐ *Aspirin* ☐ *Penicillin* ☐ *Codeine* ☐ *Local Anesthetics* ☐ *Acyrlic* ☐ *Metal* ☐ *Latex*

☐ *Sulfa Drugs* ☐ *Others*

If yes, please list and explain: _____

_____

FITZPATRICK DENTAL

Medical Information (continued)

Name of Patient _____ *Date of Birth* _____

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

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

Have you ever had any serious illness not listed above?

If yes, please explain: _____

_____

FITZPATRICK DENTAL

Dental Information

Name of Patient _____ *Date of Birth* _____

Name of Previous Dentist and Location _____ *Date of Last Exam* _____

Do your gums bleed while brushing and flossing?
☐ *Yes* ☐ *No* *Explain* _____

Are your teeth sensitive to hot or cold liquids / foods?
☐ *Yes* ☐ *No* *Explain* _____

Are your teeth sensitive to sweet or sour liquids / foods?
☐ *Yes* ☐ *No* *Explain* _____

Do you feel pain in any of your teeth?
☐ *Yes* ☐ *No* *Explain* _____

Do you have any sores or lumps in or near your mouth?
☐ *Yes* ☐ *No* *Explain* _____

Have you had any head, neck or jaw injuries?
☐ *Yes* ☐ *No* *Explain* _____

Have you have ever experienced any of the following problems in your jaw?

Clicking
☐ *Yes* ☐ *No* *Explain* _____

Pain (joint, ear, side of face)
☐ *Yes* ☐ *No* *Explain* _____

Difficulty in opening or closing
☐ *Yes* ☐ *No* *Explain* _____

Difficulty in chewing
☐ *Yes* ☐ *No* *Explain* _____

Do you have frequent headaches?
☐ *Yes* ☐ *No* *Explain* _____

Do you clench or grind your teeth?
☐ *Yes* ☐ *No* *Explain* _____

Do you bite your lips or cheeks frequently?
☐ *Yes* ☐ *No* *Explain* _____

Have you ever had any difficult extractions in the past?
☐ *Yes* ☐ *No* *Explain* _____

Have you ever had any prolonged bleeding following extractions?
☐ *Yes* ☐ *No* *Explain* _____

Have you had any orthodontic treatment (braces)?
☐ *Yes* ☐ *No* *Explain* _____

Do you wear dentures or partials?
☐ *Yes* ☐ *No*
If yes, date of placement _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
☐ *Yes* ☐ *No* *Explain* _____

Do you like your smile?
☐ *Yes* ☐ *No* *Explain* _____

FITZPATRICK DENTAL

Medical and Dental Certification

I certify that I have read and understand the above information to the best of my knowledge.

The above questions have been answered accurately, and I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including 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 payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature X_____ *Date* _____

Signature of patient or parent/guardian of minor

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