Amit Kumar, DDS - General Dentist
www.SmileMoreToday.com
111 North Wabash Avenue, Suite 1412, Chicago, IL 60602
Chicago: 312-624-8783
250 Center Drive, Suite 202, Vernon Hills, IL 60061
Northern Suburbs: 224-324-3151

All information is kept strictly confidential. We cannot share any information you give us to a third party without your approval.

About You

Patient Name: _____ (Last Name) _____ (Middle Name) _____ (First Name)

Preferred Name: _____

Social Security Number: ___-___-___ Date of Birth: ___/___/___ Email address: _____

Home Phone # : (___) ___ - ___ Work Phone # : (___) ___ - ___ Ext: ___ Cell Phone # : (___) ___ - ___

Home Address : _____ APT# : ___ City : _____ State : ___ Zip : _____

Employer : _____ Occupation : _____

Emergency Contact : _____ (First Name) _____ (Last Name) _____ (Relationship)

Home Phone # : (___) ___ - ___ Work Phone # : (___) ___ - ___ Ext: ___ Cell Phone # : (___) ___ - ___

Preferred Method of Contact : ☐ Phone Call ☐ Text ☐ Email

Dental Benefit Information

Dental Benefits Company: _____ Toll Free Phone Number: (___) ___ - ___

Are you the subscriber? ☐ Yes ☐ No *If Yes, skip to Group Number*

Subscriber : _____ (First Name) _____ (Last Name) ___-___-___ (Social Security #) ___/___/___ (Date of Birth)

Group Number: _____ Subscriber ID No (may be SSN) : _____

Medical Insurance Information

Primary Insurance

Insurance Company : _____ Phone Number : (___) ___ - ___

Subscriber's Name : _____ Group# : _____ Date of Birth : ___/___/___

Secondary Insurance

Insurance Company : _____ Phone Number : (___) ___ - ___

Subscriber's Name : _____ Group# : _____ Date of Birth : ___/___/___

How Did You Hear About Us?(Please select all that apply)

☐ Through a friend or family member. What is their Name? _____ First Name _____ Last Name

☐ Through our TV commercial ☐ On Comcast ☐ On RCN

☐ Through my dental benefits

☐ On the Internet ☐ Google ☐ Yahoo ☐ Yelp ☐ CitySearch ☐ Facebook ☐ Emergency Dentist 24/7

☐ Other Please Describe : _____

Health History

Physicians Name : _____ Phone # : (_____) -_____ - _____

Are you currently under this physicians care? ☐ Yes ☐ No

If Yes, What is the purpose of the current care being provided? _____

Do you have heart disease or a heart problem? ☐ Yes ☐ No Do you have a family history? ☐ Yes ☐ No

If Yes Please Describe : _____

Have you ever had or do you currently have any of the following conditions?

Bleeding Problems	☐ Yes	☐ No	Breathing Problems	☐ Yes	☐ No	Cancer/Radiation Treatment	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Unexplained weight loss	☐ Yes	☐ No
Excessive hunger	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No	Slow healing of cuts	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No	HIV / AIDS	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Obesity	☐ Yes	☐ No	Frequent Urination	☐ Yes	☐ No
Weakness & fatigue	☐ Yes	☐ No						

Acid Reflux (GERD) ☐ Yes ☐ No Treatment : _____

MyoFacial Pain ☐ Yes ☐ No Treatment : _____

Headaches :

Tension Headaches ☐ Yes ☐ No Treatment : _____

Migraine Headaches ☐ Yes ☐ No Treatment : _____

Morning Headaches ☐ Yes ☐ No Treatment : _____

Snoring and Sleep Apnea :

Snoring	☐ Yes	☐ No	Treatment : _____					
Sleep Apnea	☐ Yes	☐ No	Restless sleep	☐ Yes	☐ No	Loss of energy	☐ Yes	☐ No
Excessive daytime sleepiness	☐ Yes	☐ No	Dry or sore throat	☐ Yes	☐ No	Weight gain	☐ Yes	☐ No
Using CPAP	☐ Yes	☐ No	Depression, irritability or difficulty concentrating	☐ Yes	☐ No			
Had Sleep Test in Last 3 Years?	☐ Yes	☐ No	Have a Copy of the Sleep Test Result?	☐ Yes	☐ No			

Diabetes :

Diabetes ☐ Yes ☐ No ***If Yes*** Is it under control? ☐ Yes ☐ No Family History of Diabetes ☐ Yes ☐ No

Are you prone to diabetic complications? ☐ Yes ☐ No

How do you monitor your blood sugar? _____ Who treats your diabetes? _____

Any other medical conditions, please describe : _____

Has a physician or dentist ever recommended you take antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently using Blood Thinners or have you ever used them in the past? ☐ Yes ☐ No

Do you now or have you ever used the following : ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew

If so, How much per day? _____ How many years? _____ If you quit, list what year _____

Are you allergic or have you had a bad reaction to any of the following?

Local anesthetic (Novacaine) ☐ Yes ☐ No Penicillin ☐ Yes ☐ No Latex ☐ Yes ☐ No

Anything else Please Describe : _____

Do you get regular exercise? ☐ Yes ☐ No

What medications are you taking right now and for what condition?

Include prescription and over the counter : *Example: Prilosec for acid reflux*

Medication		**Condition**
_____	**for**	_____
_____	**for**	_____
_____	**for**	_____
_____	**for**	_____
_____	**for**	_____

Female Patients :

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you currently taking birth control? ☐ Yes ☐ No

Are you menopausal? ☐ Yes ☐ No If so, are you taking estrogen/hormone replacement therapy? ☐ Yes ☐ No

Are you currently taking any medication to increase bone density? ☐ Yes ☐ No

Dental History

Why are you here today? _____

Who was your last dentist? **Dr.** _____ When was the last time you saw a dentist? ____/____/____

Why did you decide to change dentists? _____

Have you ever had an unpleasant dental experience? ☐ Yes ☐ No

If Yes Please Describe: _____

TMJ Disorder ☐ Yes ☐ No Treatment : _____

How is your current dental health? ☐ Good ☐ Average ☐ Needs Improvement ☐ Not sure

Do your gums bleed when you brush or floss? ☐ Never ☐ Sometimes ☐ Almost Every Time

How would you describe your parent's dental health? _____

What is the level of dental treatment are you interested in?

☐ Emergency or Urgent care needs where pain exists or something is wrong.

☐ Preventative care to stop problems before symptoms occur.

What do you want to improve with your smile and health?

☐ Whiteness	☐ Replace Missing Teeth	☐ Staining/Discoloration	☐ Straighten teeth
☐ Teeth Grinding & Clenching	☐ Existing Dental Work	☐ Replace Denture/Partial Denture	☐ Dry Mouth
☐ Remove unsightly silver/black mercury fillings	☐ Chipping or Cracking	☐ Smile Makeover / Veneers	☐ TMJ treatment
☐ Pain/Discomfort	☐ Reduce Headaches	☐ Headache treatment	☐ Bad Breath
☐ Stop Choking and Gasping During Sleep	☐ Stop Snoring	☐ Sleep Apnea	☐ Replace my CPAP

☐ Botox ® Cosmetic to reduce expression lines/wrinkles

☐ Botox ® Therapeutic for TMD, clenching and headache treatment

☐ Gum Health/Appearance/Smile Line (Do you see enough/too much of your gums?)

☐ Other _____

If you could change anything about the appearance of your smile, what would it be?

_____

General Office Information

With your permission, we may take x-rays and photographs to evaluate your dental health. Video and audio recording devices may be used to monitor consultations and treatment to ensure a high quality experience for all of our patients. We will not share any of your personal information with anyone outside of this office without your consent.

24-Hour Cancellation Policy

When we reserve time for your appointment, we make room in our schedule so we may devote our time and focus our efforts on serving your needs. Late cancellations mean we have empty time in our schedule when we could have been helping another patient. **There is a $25 per hour charge for reserved appointments, broken or changed by the patient without 24 hour notice.**

☐ I understand and agree with the Office Policies of Smile More Today.

Payment Plans / Financing / Credit

How will you be paying for your treatment today and in the future?

_____

Are you interested in learning about flexible third party financing plans available to you? ☐ Yes ☐ No

Are you interested in exploring interest free financing? ☐ Yes ☐ No

Financial Policy

You are responsible for the **total fee** for services performed at this office. Cash and all major credit cards are accepted as payment for services at Smile More Today. Checks are accepted with a valid credit card on file.

If we receive payment after 21 days from your benefits company, it will be applied to your account and you will receive a statement from us informing you of any credit generated by the payment.

After 90 days from the date of service, any unpaid balance will be turned over to a collection agency. This is our standard policy for all delinquent accounts. Once an account is sent to collections, you must pay the collection agency. You will no longer be able to pay us directly for the balance.

In accordance with HIPAA, I agree to Smile More Today use and disclosure of my protected health information to my benefits company. I understand that my benefits company will send payment directly to Smile More Today unless prior arrangements have been made.

It is each patient responsibility to make a determination if they have active insurance coverage. Patients that receive treatment and later find out they are not active are responsible for the full amount of services provided.

For patients who choose to have us bill insurance and are unwilling to pay the full amount at the time of service, and would rather wait for reimbursement, we require a credit card on file in the event that the insurance company fails to pay or insufficient payment is received. At the receipt of insurance reimbursement and explanation of benefits the patient will be informed that the remaining balance will be placed on their card before the card is charged.

We are in-network with select PPO dental benefit plans. We will bill the benefit plan on behalf of the patient once the service has been started.

In the unfortunate event of failure to pay outstanding bills in a timely manner we will reserve the right to turn the amount over to a credit agency and/or withhold services.

- ☐ All bounced checks will incur an additional fee of $35.
- ☐ I agree to pay all collection costs and reasonable attorney's fees incurred in attempting to collect on the account balance.
- ☐ I understand and agree with the Financial Policies of Smile More Today.
- ☐ I understand this office participates in the Cook County and Lake County Bad Check Restitution Program.

Acknowledgement Of Receipt Of Privacy Practices Notice

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

☐ I, _____ , have received a copy/explanation of this office’s Notice of Privacy Practices.

Signature of patient, parent or guardian	Date	Relationship to Patient Self/Other
_____	_____	_____