OAK BROOK Smiles
DR. UMAR HAQUE

About you

Patient Name:_____
First MI Last Preferred Name

Social Security Number: _____ Date of Birth: _____
000-00-0000 mm/dd/yyyy

Email address: _____

Phone: _____
Home Cell Work

Address: _____
Street Apt # City State Zip Code

Employer: _____ Occupation: _____

Emergency Contact: _____
First Last Relationship

Phone: _____
Home Cell Work

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

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

☐ Through my dental insurance ☐ Facebook ☐ Suburban Woman Magazine ☐ Yelp

☐ Yahoo (Keyword:_____) ☐ Google (Keyword:_____) ☐ Other (Describe:_____)

Insurance Information

Insurance Company: _____ Toll Free Phone Number: _____

Are you the subscriber? ☐ Yes ☐ No (if yes skip to Group Number)

Subscriber: _____
First Last Social Security Number Date of Birth

Group Number: _____ Subscriber ID Number (may be SSN): _____

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Medical History

Patient: _____ **Date:** _____ **Date of Birth:** _____

Allergies: **Penicillin** **Metal** **Aspirin** **Ibuprofen** **Latex** **Milk**

Other: _____

Do you have any **Heart Conditions?** **Yes** **No** Dates: _____

Heart Attack **Pacemaker** **Murmur/MVP** **Birth abnormality in Heart** **High Blood Pressure**

Have you ever had **Cancer?** **Yes** **No** If yes, type: _____

Radiation **Chemotherapy** **Head & Neck** Dates of treatment: _____

Do you have **Diabetes?** **Yes** **No** Blood sugar, frequency: _____

Type: _____ HgA1C level/How often: _____ Glucose Tabs: _____

Do you have any **Autoimmune Diseases?** **Yes** **No** Type: _____

Common Autoimmune diseases include (circle): **Lupus** **Rheumatoid Arthritis** **Fibromyalgia**
Multiple Sclerosis **Thyroiditis**

Do you have: **Herpes** **HIV/AIDS** **Hepatitis** **HPV**

Are you currently experiencing: **Puberty** **Pregnancy** **Nursing** **Menopause** **Osteoporosis**

Have you ever taken **Fosamax, Boniva, Actonel** (Bisphosphonates)**?** **Yes** **No**

How long ago? _____ Duration? _____

Are you taking: **Birth control** **Hormone replacement** **Fertility medications**

Do you have **Artificial Joints?** **Yes** **No** When were they placed: _____

Have you ever had any **Thyroid problems?** **Yes** **No**

Do you have: **Asthma** **Epilepsy** **Acid Reflux** **Parkinson's** **Dry Mouth** **Excessive thirst**

Headaches **Snoring** **Jaw pain** **Popping in the jaws** **Clicking in the jaws**

High blood pressure Excessive alcohol use Tobacco use

Have you ever been required to pre-medicate with antibiotics before dental work? **Yes** **No**

Medications: _____

Physician: _____ **Phone number:** _____ **Town/City:** _____

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: _____

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Why did you come in today? _____

_____

When was your last dental cleaning? _____

_____

Have you ever had a deep cleaning or other periodontal work? _____

_____

On a scale of 1 to 10 (1 being the lowest and 10 being the highest) please rate the following:

Importance of your smile to you	1	2	3	4	5	6	7	8	9	10
Rate your smile	1	2	3	4	5	6	7	8	9	10
Importance of your dental health	1	2	3	4	5	6	7	8	9	10
Rate your daily oral hygiene routine	1	2	3	4	5	6	7	8	9	10

If you could change one thing about your smile, what would it be? _____

_____

What have you tried in the past? _____

Are you happy with the results? _____

Does getting dental treatment make you nervous or anxious? Yes No

Would you like Nitrous Oxide (laughing gas) during longer procedures? Yes No

Please write down any specific questions you would like for us to address today.

_____

_____

Please list the last 3 dentists (including specialists) that you have seen within the past 5 years, or are currently seeing.

Dr. _____Office location_____

Dr. _____Office location_____

Dr. _____Office location_____

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24-Hour Cancellation Policy

When we reserve an appointment for you, we make room in our schedule to devote the time and care necessary for your needs. Late cancellations and no shows result in empty space in the schedule which could have been used assisting another patient. **Failed appointments or cancellation of reserved appointments with less than 48 business hours notice may result in fees of up to $50 per hour reserved.**

Appointment Reservation Fees

We strive to provide our patients the best treatment with the newest technologies on the market. Some appointments may require several hours and this time is held especially for you. Because of this, a deposit of $50.00 per hour for any treatment appointment over one hour will be required to reserve the appointment time. This deposit will be applied to the cost of the treatment. **If for any reason you must cancel or reschedule, 48 business hours notice must be given or the deposit will become non-refundable.**

Financial Policy/Insurance

All dental services rendered, whether or not covered by insurance, are ultimately your financial responsibility. If you have dental insurance, we will verify your benefits prior to treatment. If for any reason we are unable to verify your dental benefits you will be responsible for all treatment fees **IN FULL** at the time of service. We will gladly submit a claim to your insurance company and they will reimburse you directly. If we have been able to verify your dental benefits, we will give you an **ESTIMATE** of what we expect your insurance to pay and collect the difference from you at the time of service. You are responsible for any remaining balance once the insurance claim has been processed. We accept cash, check, all major credit cards, and low interest financing through Care Credit. We will submit claims to your insurance on your behalf, but it is your responsibility follow up with unpaid claims. Balances on insurance claims over 90 days old will become your responsibility. Past due account balances over 90 days old (without a payment arrangement in place) will be turned over to a collections agency and you will be responsible for any collection costs and attorney fees incurred.

General Consent

The medical information you have disclosed is necessary to provide you with dental care in a safe and efficient manner. Please be advised that in order to properly diagnose any treatment that you may need, x-rays, study models, photographs, or any other diagnostic aids may be deemed necessary and appropriate by Dr. Haque.

I authorize Dr. Haque to perform any and all forms of consented treatment, medication, and therapy that may be indicated in connection with said patient, and further authorize and consent that Dr. Haque choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

*****HIPAA DISCLOSURE:** Oak Brook Smiles protects your privacy and will not share information regarding your treatment, diagnosis, or account without your written consent. HIPAA does not restrict sharing of private health information with providers for treatment-related services or with your insurance. If you wish to grant a loved one access to your information you must fill out a privacy waiver.

I understand and agree with the policies set forth by Oak Brook Smiles.

_____

(Print Name) Date

_____

(Signature) (Relationship to Patient)