DENTAL Essence
Comprehensive Family & Cosmetic Dentistry

DENTAL ESSENCE
PAUL N GREICO DDS
COMPREHENSIVE FAMILY & COSMETIC DENTISTRY

WWW.DENTALESSENCE.COM
Tel: 630-250-0333
1576 W LAKE STREET, SUITE 102
ADDISON, ILLINOIS 60101

PATIENT INFORMATION

Date: ..... ☐NEW PATIENT ☐UPDATE

Patient: .....
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: ..... Patient SSN: .....

Address: .....
ADDRESS LINE 1

.....
ADDRESS LINE 2

.....
CITY ST ZIP CODE

E-Mail: .....

HOME: .....
CELL: .....
OTHER: .....
PAGER: .....
FAX: .....

Referral? ☐Yes ☐ No Referred by: .....

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

..... Tel: .....
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: ..... Occupation: .....

Address: .....
ADDRESS LINE 1

.....
ADDRESS LINE 2

.....
CITY ST ZIP CODE

E-Mail: .....

WORK: X
DIRECT: .....
OTHER: .....
PAGER: .....
FAX: .....

INSURANCE INFORMATION

Subscriber: .....
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: ..... Subscriber SSN: .....

Subscriber Employer: .....

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: .....

Group/Policy No.: ..... ID No.: .....

Address: .....

.....

.....
CITY ST ZIP CODE

TEL: .....
TOLL-FREE: .....
FAX: .....

SECONDARY INSURANCE CARRIER: .....

Group/Policy No.: ..... ID No.: .....

Address: .....

.....

.....
CITY ST ZIP CODE

TEL: .....
TOLL-FREE: .....
FAX: .....

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____ _____ _____

CITY ST ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Do you mouth breathe while awake or asleep?

☐Y☐N Does it hurt to bite or chew or do you experience any sensitivity to hot, cold, pressure, etc.?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you have any mouth habits? (ex. biting nails, cheeks, pencils, grinding teeth, etc.)

☐Y☐N Do you prefer NOT to have anesthetic for dental work?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

How often do you brush your teeth? _____

How often do you floss? _____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y☐N Any unusual speech habits? If yes, explain: _____

☐Y☐N Any lost teeth? If yes, list: _____

☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Use alcohol? If Yes, how often?
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

_____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ALZHEIMER'S/DEMENTIA
☐ANEMIA
☐ANXIETY
☐ARTERIOSCLEROSIS
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS/RHEUMATISM
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BLOOD TRANSFUSION
☐BREATHING PROBLEMS
☐BRUISE EASILY
☐CANCER/TUMOR
☐CHEMOTHERAPY/RADIATION
☐CHEST PAIN
☐CHRONIC COUGH
☐COLD SORES/FEVER BLISTERS
☐CONGENITAL HEART DISEASE
☐CORTISONE MEDICINE
☐COSMETIC SURGERY
☐DEVELOPMENTALLY DISABLED
☐DIABETES
☐DIET (SPECIAL/RESTRICTED)
☐DIZZINESS/FAINTING
☐DRUG ADDICTION
☐EMPHYSEMA
☐EPILEPSY/SEIZURES
☐GLAUCOMA
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS A (INFECTIOUS)
☐HEPATITIS B (SERUM)
☐HAY FEVER
☐HIGH BLOOD PRESSURE
☐KIDNEY TROUBLE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐NEUROLOGICAL DISORDER
☐PACEMAKER
☐OTHER – PLEASE LIST:
☐PSYCHIATRIC TREATMENT
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SICKLE CELL DISEASE
☐SINUS PROBLEMS
☐SWOLLEN ANKLES
☐THYROID PROBLEMS
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE
☐YELLOW JAUNDICE

_____
_____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐SLEEPING PILLS
☐METAL SENSITIVITY
☐EPINEPHRINE
☐PENICILLIN/OTHER ANTIBIOTICS
☐SULFA DRUGS
☐NUTS
☐NONE
☐OTHER – PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all PPO dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - Various financing options with CareCredit®

Short Cancelled/ Missed Appointments

- **Please give 24 hours notice** if you are unable to keep your reserved time. Missed appointments without a 24 hour notice are subject to a $50 same-day cancellation fee.

Notice of Privacy

To request privacy restrictions, you must make your request in writing to Dental *Essence*®*.* In your request, you must tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply.

- **Right to request confidential communications:** You have the right to request that we communicate with you about medical/dental matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Dental *Essence*®. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a paper copy of this notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a paper copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical/dental information we already have about you, as well as any information we will receive in the future. The notice will contain, on the first page, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the office of the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

Other Uses of Medical/Dental Information

Other uses and disclosures of medical/dental information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us with an authorization to use or disclose medical/dental information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose medical/dental information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENTS ACKNWLEDGEMENTS OF RECIEPT OF NOTICE OF PRIVACY RULES:

I_____, have received a copy of the Notice of Privacy practices of the office of Dental *Essence®.*

OPTING OUT:

☐ I do not want appointment reminder messages left on my home answering system. I understand that the office may charge me $50.00 should I fail to keep my appointment.

☐ I do not want appointment reminder messages left on my business answering system. I understand that the office may charge me $50.00 should I fail to keep my appointment.

☐ I do not wish my healthcare information to be released to the following persons: _____

_____

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Greico of the dental benefits otherwise payable to me.

I hereby authorize Dr. Greico to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

SIGNED_____DATE_____/_____/_____

_____

For Office Use Only:

Signature of Doctor _____ DATE_____/_____/_____