

dental salon

939 W North Ave Suite 800 Chicago, IL 60642
312.642.3370
www.dentalsalon.com

Thank you for choosing Dental Salon for your Child/Minor's dental care. All information is kept strictly confidential. We cannot share any information you give us to a third party without your approval.

Today's Date: _____
mm/dd/yyyy

About Child/Minor

Child/Minor Name: _____
First MI Last Preferred Name
Social Security Number: _____ Date of Birth: _____ Male Female
000-00-0000 mm/dd/yyyy

Parent/Guardian Information

Please provide two contacts if possible.

-First contact

Name: _____
First MI Last Preferred Name Relationship to Child/Minor
email address: _____ Phone: _____
Mobile Other
Address: _____
Street Apt # City State Zip Code
Employer: _____ Occupation: _____

-Second contact

Name: _____
First MI Last Preferred Name Relationship to Child/Minor
email address: _____ Phone: _____
Mobile Other
 Check if address is same as First Contact
Address: _____
Street Apt # City State Zip Code
Employer: _____ Occupation: _____

Insurance Information

Is Child/Minor covered under a dental insurance plan?

Insurance Company: _____ Toll Free Phone Number: _____ Group Number: _____
Which of the contact above is the subscriber? First Contact Second Contact _____
Date of Birth Social Security #
Subscriber ID Number (may be SSN): _____

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

Through a friend or family member
What is their Name?

First

Last

Through our TV commercial

On Comcast

On RCN

On the Internet

Google

Yahoo

Yelp

CitySearch

Facebook

Emergency Dentist 24/7

Through our dental insurance

Other

Please describe:

Dental History

Why is Child/Minor here today? _____

Date of last dental visit? _____ Who was the last dentist Child/Minor saw? Dr. _____

Has Child/Minor ever had an unpleasant dental experience? (if yes, please describe) Yes No

How is your Child/Minor's current dental health?

Good

Average

Needs Improvement

Not sure

Does Child/Minor brush teeth daily?

Does Child/Minor floss teeth daily?

Is fluoride taken in any form?

Any injuries to mouth, teeth, head?

Yes

No

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc?

If **Yes** to any mouth habits please circle above which and describe: _____

Health History

Child/Minor's Physicians Name: _____ Phone Number: _____ Date of Last Visit: _____

Is your Child/Minor currently under this physicians care? Yes No

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

Taking any medication or drugs? **Yes** **No**

Ever been hospitalized?

Ever had surgery?

Is there excessive bleeding when cut?

Medications: _____

Allergies: _____

Has Child/Minor ever had or do they currently have any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Issues	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other

Any other medical conditions, please describe: _____

Has a physician or dentist ever recommended Child/Minor take antibiotics before dental treatment? Yes No

Is Child/Minor allergic or had a bad reaction to any of the following?

	Yes	No
Local anesthetic (novacaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>

Anything else (please describe): _____

I have completed the above information to the best of my knowledge. I understand that it is my responsibility as parent/guardian to inform Dental Salon if Child/Minor ever has a change in health.

Child/Minor Consent

I am the parent/guardian of _____
Print Name of Child/Minor

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize Dental Salon to perform necessary dental services for the Child/Minor named above, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor whether or not I am present when the treatment is rendered.

Insurance Assignments and Release

I certify that Child/Minor named above is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dental Salon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dental Salon may use above named Child/Minor's health care information and may disclose such information to above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Parent/Guardian Date Print Name Parent/Guardian Relationship to Child/Minor

General Office Information

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

Referral Rewards Program

The program is simple - for every referral you send to our office, we will give you a \$25 credit to your account. Make sure you get credit for everyone you refer! Credits are processed at the beginning of every month.

24-Hour Cancellation Policy

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

Palliative Treatment on Emergency Visits

It is Dental Salon’s policy to charge a minimum of \$50 for palliative treatment for emergency visits that require a prescription.

Ps and Qs

Please turn off mobile phones when seated in the dental chair. This is a professional office environment and use of inappropriate language and/or actions will not be tolerated. Thank you.

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 Dental Salon. Checks are not accepted.

If you have insurance, we are obligated to bill your insurance for all procedures completed on your behalf. Cosmetic procedures may not be billed to insurance.

If you have insurance, we will provide an **estimate** of what we think your insurance company will **probably** pay and collect the difference from you at the time of service. If you want a more exact estimate, we will need to send a request for a **pre-treatment estimate** to your insurance company. This can take several weeks to be returned to us.

If the insurance company pays more than we expected, you will have a credit on your account. We will mail you a statement informing you of the credit. You can keep it on your account or we can refund it to you. All outstanding insurance claims must be received before we may issue any refunds.

If the insurance company pays less than we expected or not at all, **you are responsible** for the difference between what you have already paid and your total fee.

We will try to arrange payment from your insurance company for a maximum of 45 days. **After 45 days, you are responsible for any balance on your account, regardless of whether your insurance company has paid us or not.**

If we receive payment after 45 days from your insurance 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 75 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.

Stop! Do not sign this if you have any questions about the financial policies of our office. If you do have questions, ask one of our financial coordinators before signing.

In accordance with HIPAA, I agree to Dental Salon’s use and disclosure of my protected health information to my insurance company. I understand that my insurance company will send payment directly to Dental Salon unless prior arrangements have been made.

I understand and agree with the **Office and Financial Policies** of Dental Salon.

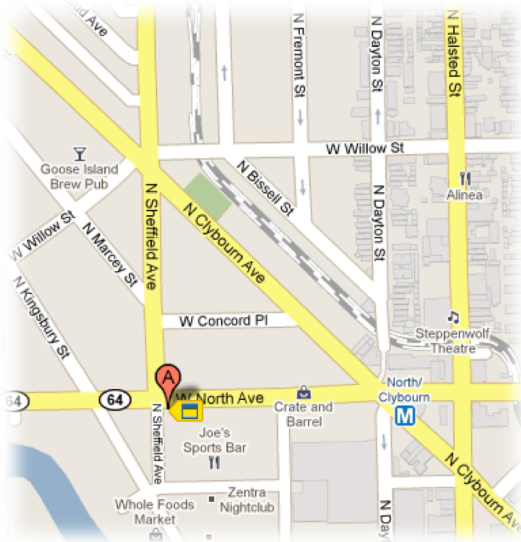
Signature of Parent/Guardian Date Print Name Parent/Guardian Relationship to Child/Minor



Where is Dental Salon...?

Dental Salon | 939 W North Ave Suite 800 Chicago, IL 60642 | (312) 642-3370
dentalsalon.com | dentalteam@dentalsalon.com

We're on the map!



Have a smartphone?
Use our QR code for detailed directions from Google maps!



Dental Salon is located in the North Avenue Collection Building at the corner of *North Ave. and Sheffield Ave.* in the same building as Fitness Formula Clubs.

We offer discount validated parking in the garage attached to our building. Dental Salon has no control over parking rate changes. Current Standard Parking rates with Dental Salon validation stamp are as follows: 0-1 hour \$0 | 1-2 hour \$5.50 | 2-3 hour \$9.50 | 3-4 hour \$13 | 4-24 hour \$18



Entrance to the garage is off Sheffield Ave. just across from Starbucks. When entering the building from the parking garage, keep in mind the garage elevators are for the garage only. Please enter the building from the **third floor** of the garage, walk past FFC and take the building elevators up to the 8th floor. Dental Salon is located in suite 800 right off the elevator.

EI:

When taking the CTA's Red Line, exit the train at **North/Clybourn** (Apple store stop). Walk 2 blocks West on *North Ave.* past J Crew, Victoria's Secret and the Gap and enter the North Avenue Collection Building at the corner of *North Ave. and Sheffield Ave.* Take the elevators up to the 8th floor. Dental Salon is located in suite 800 right off the elevator.



Bus:

There is also a CTA bus stop for bus #72 right in front of our office!

-Westbound: Stop ID # 934
North Ave. & Sheffield/Kingsbury

-Eastbound: Stop ID# 910
North Ave. & Sheffield