

dental salon

501 W Golf Rd Suite B Schaumburg, IL 60195
847.805.6202
www.dentalsalon.com

**Thank you for choosing Dental Salon. 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

Patient Name: _____
First MI Last Preferred Name

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

email address: _____

Phone: _____
Mobile Other

Address: _____
Street Apt # City State Zip Code

Employer: _____ Occupation: _____

Emergency Contact: _____
First Last Relationship

Phone: _____
Mobile Other

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): _____

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 my dental insurance

Other

Please describe:

Health History

Physicians Name: _____ Phone Number: _____

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

If yes, please describe: _____

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

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Snoring / Sleep Apnea

Any other medical conditions, please describe: _____

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

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

Yes

No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 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): _____ |

Do you smoke? Yes No 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

Female Patients:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently taking birth control? | <input type="checkbox"/> | <input type="checkbox"/> |

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)

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

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 are 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.

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 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 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 you are 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.

Parking

We offer discounted 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 \$5.25 | 2-3 hour \$9 | 3-4 hour \$13 | 4-24 hour \$16

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

Printed Name

Signature of patient, parent or guardian

Date

Relationship to patient

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 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 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 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 **Financial Policies** of Dental Salon.

Printed Name

Signature of patient, parent or guardian

Date

Relationship to patient