SILVA DENTAL CENTER
5919 W. Cermak Rd. Cicero, IL 60804
Tel: (708)222-6600
Fax: (708)222-1636

PATIENT'S INFORMATION

Patient name:_____ **Date of Birth:**_____ **Gender: M / F**

Address:_____

_____

City: **State:** **Zip:**

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

Responsible Party

Name:_____ **Date of Birth:**_____ **Relationship to Patient:**_____

Address:_____ **Cell Phone:**_____ **Email:**_____

Employment Information

Employer Name:_____**Occupation:**_____

Address: _____

Phone #_____

INSURANCE INFORMATION

Name of Insured:_____ **Insured's DOB:**_____

Insured's SSN: _____ **Insured's ID#:**_____

Patient's relation to Insured: **Self** __ **Spouse** __ **Child**

Ins Name and Address:_____

Who may we thank for referring you to our office?

Online:_____ **Current Patient:**____ **Friend/Relative**:____

REFERRED BY: (Full Name**)**_____

PATIENT NAME: _____ **Birth Date:** _____

Phone:_____ **Address**:_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

Comments: _____

_____

_____

_____

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 _____

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment for services is due at the time services are rendered. We accept cash, checks, and credit card payments. We process any insurance claims for you and we do accept insurance assignment. We will do our very best to accurately **ESTIMATE** what your insurance company will pay towards normally covered services. Please understand however, our calculations are strictly **ESTIMATES** and are no guarantee that your insurance company will reimburse us according to these estimates. Ultimately, your insurance is a contract between you and your insurance carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility.

Returned checks will have a charge of **$ 25.00** and balances older than 30 days will be subject to additional collection fees and interest charges. A charge of **$ 30.00** may also be made for broken appointments and appointments cancelled without 48 hours advance notice, Monday-Friday, **$50.00** for a Saturday appointment and **$75.00** if the appointment is scheduled with one of our specialists. **Any attorney or collection fees incurred due to delinquency in payment will also be charged to patient.** I hereby acknowledge that I have read this document and understand my financial responsibility for dental services provided for myself and other patients whose names I have provided to appear on my account as responsible party.

Sign: _____ **Date:** _____

SILVA DENTAL CENTER, LTD

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, *SILVA DENTAL CENTER, LTD.,* may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to *SILVA DENTAL CENTER, LTD.,* Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. *SILVA DENTAL CENTER, LTD.,* reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *SILVA DENTAL CENTER, LTD.,* Privacy Officer at 5919 West Cermak Road, Cicero, IL 60804.

With my consent, *SILVA DENTAL CENTER, LTD.,* may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, *SILVA DENTAL CENTER, LTD.,* may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, *SILVA DENTAL CENTER, LTD.,* may e-mail me or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that *SILVA DENTAL CENTER, LTD.,* restrict how it uses or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to *SILVA DENTAL CENTER'S, LTD.,* use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, *SILVA DENTAL CENTER, LTD.,* may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ ___ _____

Patient's Name **Date**

_____

Print Name of Patient or Legal Guardian

Personal Health Information Disclosure Agreement

Silva Dental Center

I, _____, do hereby grant permission for
(Parent/guardian name OR Self)
SILVA DENTAL CENTER, to disclose personal health information or the personal health information of _____ to the following personal
(Please print child name)
representatives(s): (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

_____

_____

Information to be disclosed (please check):

- Appointment dates and times ☐
- Treatment plans and referrals ☐
- Financial and billing information ☐
- Any other pertinent dental health information related to treatment at this office ☐
- None of the above (please explain) ☐

_____

_____

I understand that this permission will remain in effect unless a written cancellation has been provided to **SILVA DENTAL CENTER**

_____
Patient's or Legal Guardian's Signature Date

_____
Patient's Date of Birth