



Patient Information

Email _____

Name of other dependents under this plan _____

Name of other dependents under this plan

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe _____

Are you currently under physician care? ☐ Y ☐ N If yes, describe _____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Acid Reflux | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autism | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | | | |

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.



A FAMILY PRACTICE THAT TREATS YOU LIKE FAMILY™

Notice of Privacy Practice

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 04/13/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain. Including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. For example: **Treatment:** We may use or disclose your health information to a physician or healthcare provider providing treatment to you. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, digital photographs, or similar forms of health information.

marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Romeoville, IL | Naperville, IL | Montgomery, IL

vvdental.com

(815) 372-0100



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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly,
- Obtain payment from third-party payers for my health care services (insurance companies, collection service agencies, etc.)
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

Patient Name: _____ Date of Birth: _____

I authorize the release of information such as, but not limited to: diagnosis, treatment plan, billing/statement information, insurance and claim information to:

☐ Spouse _____ ☐ Child (ren): _____

☐ Parents _____ ☐ Other: _____

Patient or Guardian signature _____ Date _____

Cosmetic Dentistry- Model Release

I, (PLEASE PRINT) _____ (___ give/ ___ do not give) Valley View Dental permission to record the image and/or voice (testimonial) of the patient named below and I grant Valley View Dental all rights to use these sounds, still or moving images in any medium for educational, promotional, advertising or other purposes that support the mission of the dental practice. I agree that all rights to the sound, still or moving images belong to Valley View Dental.

Patient's Name
(print) _____

Guardian's name (print-only needed if minor is under 18) _____

Patient or Guardian signature

Date

441 N. Weber Rd.
Romeoville, Illinois 60446
815-372-0100
Fax 815.372.0300

3103 111th Street, Suite 131
Naperville, Illinois 60564
630-904-5600
Fax 630.904.5615

1078 Ogden Avenue
Montgomery, IL 60538
630-923-0900
Fax 630.686.6362



A FAMILY PRACTICE THAT TREATS YOU LIKE FAMILY™

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill and keeping your scheduled appointments is considered part of your treatment program. Your clear understanding of the Financial Policy and Cancellation Policy is important to our professional relationship. Please talk to your office team if you have any questions.

Financial Policy

- **Full Payment is due at the time of service.**

Our office accepts assignment of insurance benefits. We verify eligibility for all insurances; if your insurance company is expected to pay a portion of your bill, we will wait for that portion from them. It is your responsibility to pay co pays, deductibles and any amount not expected from your insurance at the time treatment is provided. If you do not have insurance, or if our office does not accept assignment from your insurance company, then payment is due in full at the time of treatment. If the balance is not paid at the time of service, for whatever reason, it is agreed that our office is extending credit to you as a courtesy. If credit is extended, you authorize our office and/or agents to access your consumer credit report.

If your insurance company has not paid the full balance within 60 days, the balance of your account will become your responsibility. Please be aware that some and perhaps all of the services provided maybe “non-covered” services and not considered necessary under your dental insurance. An example of such a service is “tooth colored” composite fillings. Many insurances only pay for metal fillings; in such a case, you will be responsible for the difference in cost.

In addition, your insurance company may pay based on fees considered “usual and customary” that differ from ours. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our patients. You are responsible for payment in full regardless of your insurance company’s arbitrary determination of “usual and customary” rates.

Please remember that insurance is a contract between you and your insurance company. Our office is not a part of this contract. **You are responsible for the timely payment of your account.** In the event that your account is sent to collections, you will be responsible for all costs of collection and reasonable attorney’s fees.

Our office accepts cash, check (with valid ID), Visa, MasterCard, American Express, Discover, Care Credit and citihealth..

Cancellation Policy

- **48 hour notice is required to change a scheduled appointment. A \$50 fee will be applied for all appointments cancelled or failed without 48 hour notice.**

We believe that the dental appointment represents a shared responsibility for both the doctor and the patient. In order to have quality dental care at an affordable cost, these appointments must be kept.

In the event that you need to change a scheduled appointment, our office requires 48 hour notification. If an appointment is not kept or is changed within 48 hours, future appointments will only be held if you contact our office to confirm those appointments. If you fail to confirm your appointments, our office reserves the right to cancel your appointment or those of your family members. After two missed appointments we will no longer be able to reserve appointment time for you in advance.

Thank you for understanding our Financial Policy and our Cancellation Policy. Please let us know if you have any questions or concerns.

I have read the above and fully understand the terms thereof.

Signature (Parent or Guardian if patient is a minor):

Date