PATIENT INFORMATION

Name:_____ DOB:_____ Soc Sec#:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone #:_____ Email:_____

Home #:_____ Work #:_____

If student, name of college:_____ City:_____ State:_____

If employed, name of employer:_____ City:_____ State:_____ Phone:_____

If spouse employed, name of employer:_____ City:_____ State:_____ Phone:_____

Person to contact in case of emergency:_____

Name of Person Responsible for this acct:_____ Relationship to patient:_____

Address if different from above:_____ Home Phone:_____

Driver's License#:_____ State:_____ DOB:_____ SS#:_____

Name of Employer:_____ Work #:_____ Cell #:_____

How did you hear about us?_____

What is the reason for today's visit?_____

How would you rate your smile?_____

Would you like to change anything about your smile?_____

What did you like most about your last dentist?_____

What did you like least about your last dentist?_____

Why did you leave your last dentist?_____

Are you interested in receiving any information on Botox Cosmetic or Fillers?_____

ZAIBAK CENTER FOR DENTISTRY OFFICE POLICIES

MISSED APPOINTMENTS:
Unless cancelled or rescheduled at least 24 hours in advance, our policy is to charge $100.00 for missed appointments. This fee must be paid before another appointment can be scheduled.

REGARDING INSURANCE:
If you have insurance, we require your estimated portion to be paid at the time of service. It is your responsibility to pay the remaining balance not covered by your insurance company. Please be aware that some, or all of the services provided may be considered a non-covered procedure by your insurance company. If there is no insurance involved, payment is due when services are rendered.

FINANCIAL RESPONSIBLE PARTY:
I hereby agree to the following terms and conditions:
There is a 1.5% monthly late charge assessed on all balances after 60 days past due. A $10 late charge will be assessed on all balances past 90 days. Checks, which are declared non-sufficient funds, will be charged a $35 service fee. Also, the undersign agrees to pay all collection costs, all attorney fees and court cost incurred by the creditor in an amount not to exceed fifty percent (50%) of the total owed when sent to collection.

AUTHORIZATION FOR DENTAL TREATMENT:
I hereby authorize Dr. Zaibak and his associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care. I am informed and fully understand that there are risks with any of the above procedures. The most common risks can include, but are not limited to: Bleeding, swelling, cold/heat sensitivity, soreness when chewing or biting, bruising, discomfort, still jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction and cardiac arrest. Sensitivity to resin composites may lead to future root canal. Risk associated with root canal may be separation of instrument in canal. A crown should be placed on tooth after completion of root canal treatment, or risk failure of root canal. I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medications as directed. Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

PRIVACY PRACTICES ACKNOWLEDGEMENT:
The privacy of your medical information is very important to us and we are committed to protecting it. Please ask the front desk for a copy of our privacy policy if you are not already familiar with it.

I have read and understand the above policies:

Signature of patient or responsible party_____ **Date**_____

Patient Medical Information

Patient name: _____ Date: _____

Physician: _____ Office #: _____ Date of last exam: _____

Are you under medical treatment now? Yes No

Are you taking any medication (s) including non-prescription medicine? Yes No

If yes, what medication (s) are you taking?

_____

_____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs? Yes No

If yes, please explain: _____

_____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you pregnant or think you may be pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Are you allergic to or have you had any reactions to the following?

Local anesthetics (ex. novocaine)	**Yes No**
Penicillin	**Yes No**
Sulfa drugs	**Yes No**
Barbiturates	**Yes No**
Aspirin	**Yes No**
Sedatives	**Yes No**
Iodine	**Yes No**
Latex rubber	**Yes No**
Any metals (eg. Nickel, mercury etc)	**Yes No**
Other antibiotics -please list_____	**Yes No**
_____	
Other _____	**Yes No**
_____	

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

High blood pressure	Yes No	Heart disease	Yes No	Chest pains	Yes No
Heart attack	Yes No	Cardiac Pacemaker	Yes No	Anemia	Yes No
Rheumatic fever	Yes No	Heart murmur	Yes No	Stroke	Yes No
Swollen ankles	Yes No	Angina	Yes No	Hay fever/Allergies	Yes No
Fainting/Seizures	Yes No	Mitral valve prolapse	Yes No	Tuberculosis	Yes No
Asthma	Yes No	Emphysema	Yes No	Radiation therapy	Yes No
Low blood pressure	Yes No	Artificial valves/other valves	Yes No	Glaucoma	Yes No
Epilepsy/Convulsions	Yes No	Cancer	Yes No	Recent weight loss	Yes No
Leukemia	Yes No	Arthritis	Yes No	Liver Disease	Yes No
Diabetes	Yes No	Joint replacement/Implant	Yes No	Heart trouble	Yes No
Kidney disease	Yes No	Hepatitis/Jaundice	Yes No	Respiratory problems	Yes No
AIDS/HIV infection	Yes No	Sexually transmitted disease	Yes No	Frequently tired	Yes No
Thyroid problem	Yes No	Stomach troubles/Ulcers	Yes No	Other:_____	Yes No

Name of previous dentist and location: _____ Date of last dental exam: _____

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hot or cold liquids/foods? Yes No

Are your teeth sensitive to sweet or sour liquids/foods? Yes No

Do you feel pain to any of your teeth? Yes No

Do you have any sores or lumps on or near your mouth? Yes No

Have you had any neck or jaw injuries? Yes No

Do you wear dentures or partials? Yes No

If yes to above, date of prior placement_____

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you had any difficult extractions? Yes No

Have you had any prolonged bleeding following an extraction? Yes No

Have you experienced any of the following problems in your jaw?

Pain (joint, ear, side of face): Yes No

Clicking: Yes No

Difficulty in opening or closing: Yes No

Difficulty in chewing: Yes No

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

ZAIBAK CENTER FOR DENTISTRY

6828 W. 171st Street
Tinley Park, IL 60477
708-802-9600

LET US MAKE CONFIRMING APPOINTMENTS EASIER FOR YOU!

We will send you e-mail & text message reminders, for your convenience.

Print Name: _____

Email: _____

Mobile Phone #: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Signature: _____ **Date:** ___/____/_____
MM DD YYYY