# Benjamin S. Fiss, D.D.S., LTD.

*Changing Lives... One Smile at a Time™*

919 N. Michigan Ave.
3rd Floor
Chicago, IL 60611
312-951-5230
drfiss.com

## PATIENT INFORMATION

Date

Last Name

First Name

M.I.

Date of Birth:

Gender:

☐ Male ☐ Female

Address:

Home Phone:

Work Phone:

Cell Phone:

Email:

Who can we thank for referring you to our practice?

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## DENTAL INSURANCE INFORMATION

Name of Insured:

Insured's Birth Date:

Insured SSN:

Insurance Carrier:

ID#

Group #

Insured's Address:

Insured's Employer:

Patient's Relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Claims Mailing Address:

Do you have secondary dental insurance? If so, please provide the same information as above.

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## HEALTH INFORMATION

**Have you ever had any of the following? Please check all that apply:**

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ HIV Positive
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ **Joint Replacement**
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ **Mitral Valve Prolapse**
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Now Pregnant**
  Due Date:
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Shortness Of Breath
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Venereal Disease
- ☐ **Codeine Allergy**
- ☐ **Latex Allergy**
- ☐ **Penicillin Allergy**
- ☐ **Sulfa Allergy**
- ☐ **Local Anesthesia Reaction**
- ☐ **Shellfish Allergy**
- ☐ **Aspirin Allergy**

**Do you have any other medical conditions that we should be aware of? If yes, please explain:**

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## HEALTH INFORMATION

Have you ever had to pre-medicate for dental procedures?

☐ Yes ☐ No

Have you ever had any complications following dental treatment? If yes, please explain:

Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain:

Are you now under the care of a physician for anything other than general care? If yes, please explain:

Name of Physician:

Phone:

Please list all medications that you are currently taking:

Do you use tobacco (smoking or chewing)?

☐ Yes ☐ No

What is the reason for your visit today?

When was your last visit to the dentist?

Prior dentist's name, address and phone number:

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## HEALTH INFORMATION

How frequently do you brush your teeth?

How frequently do you floss your teeth?

Do your gums bleed when you brush or floss?

☐ Yes ☐ No

Do your teeth experience sensitivity to cold or hot temperatures?

☐ Yes ☐ No

Are any of your teeth causing you pain?

☐ Yes ☐ No

Do you grind your teeth (either consciously or during sleep)?

☐ Yes ☐ No

Are any of your teeth loose?

☐ Yes ☐ No

Do you currently have any dental implants, dentures or partials?

☐ Yes ☐ No

If you could change anything about your mouth, teeth or smile, what would it be?

To the best of my knowledge, all of the information I have provided is true and correct. If there is any change in my health, I will inform Dr. Fiss and staff at my next appointment.

Signature of patient, parent or guardian

Date

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# AUTHORIZATION AND CONSENT FOR SERVICES

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models photographs or other diagnostic aids deemed appropriate.

I authorize Dr. Fiss to release any information including the diagnosis and records of treatment or examination for my dependents, to third party insurance carriers, payors, and/or healthcare practitioners and myself. I authorize my insurance carrier to submit payment directly to Dr. Fiss to be applied to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance and that I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All dental services must be paid for at the time services are rendered unless prior financial arrangements have been made.

**All emergency dental services must be paid for in cash at the time services are performed.**

Patients with dental insurance understand that even though they have dental insurance, they are still personally responsible for payment of all dental services. The patients estimated out of pocket expense will be due at the time of service. We will help prepare as well as file insurance forms and assist in making collections from insurance companies. Any collections will be credited to the patients account.

I understand that any estimate for dental services can only be extended for a period of six months from the date of the estimate.

I have read and agree to the above conditions of treatment and payment.

Signature of patient, parent or guardian

Date

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# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**I understand that in order for you to transfer my records I must provide you with an original signed and dated letter authorizing you to do so. I understand that this authorization can not be via phone, fax or email.**

Patient Name:

Relationship to Patient:

Signature:

Date

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# INFECTION CONTROL

I have always been proud of the fact that my staff and I have excelled in many areas. Whether it means continuing education to learn new techniques or materials, having the nicest environment possible, or hiring the best staff—we always strive to be better. The main reason for this is because we feel that our patients deserve the best.

Now, with the growing concern about **AIDS** and other infectious diseases, many new regulations are being proposed by **OHSA**, **CDC**, and other agencies. In accordance with our commitment to excellence, I have chosen not to wait on regulations that **require compliance**. I am committed to incorporate new techniques and materials related to infection control as **they become available**. I am sure you have already noticed the many changes implemented over the years. I plan to make others in the future.

This peace of mind for you (and my entire office) does not come easily or without considerale expense. More labor time is spent in cleaning rooms and equipment. More behind the scenes equipment, such as chemical-heat sterilizers and atuoclaves for instruments are needed. More disposable materials are used (my office is the first in Chicago to use **hospital-type sterile packs**). Each one of our clinical staff members have been vaccinated for hepatitis and have gone through hazardous material management training.

Up to this point I have absorbed most of the costs of infection control. In order to cover the increasing cost of infection control fairly; some additional charge to the patient must be incurred rather than increase the fees across the board (which would penalize someone having multiple treatments done in one visit), I have decided to charge a flat infection control fee of $10.00 for each visit. While not all insuance companies presently cover this charge; **many do**, and it is something that should become commonplace and accepted over time. You can help by contacting your insurance in the event of non-payment.

My staff and I want to answer any questions you have concerning our procedures. Please feel free to ask us anything, whether during a visit or by phone. We know you expect the best dental care we can offer, and **we care about you!**

I acknowledge that I have received, read and understand Dr. Fiss' infection control protocol.

Signature of patient, parent or guardian

Date