Confidential Dental and Medical History

Patient's Name _____ Age_____ Date of Birth _____

Address _____ City, State, Zip_____

Home Phone _____ Work _____ Cell _____

E-mail _____ Best Contact- **EMAIL CELL TEXT HOME** Best Time to Reach You- _____

SS# _____ Marital Status: **SINGLE MARRIED WIDOWED DIVORCED**

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Phone: (Work) _____ (Cell) _____

Emergency Contact _____ Relation _____ Emergency Phone _____

Do you have dental insurance? **YES NO** If YES, Insurance Carrier's Name _____

Group # _____ Phone _____ Subscriber's Name _____

Relation to Patient _____ Subscriber's SS# _____ Subscriber's Date of Birth _____

Employer/Co. Name _____ Phone _____

Employer/Co. Address, City, State, Zip _____

Insurance Carrier Address,City,State,Zip _____

HOW DID YOU HEAR ABOUT US ? _____

Would you like to receive appointment reminders via text message? **YES NO**

SIGNATURE OF PATIENT OR GUARDIAN **PRINT NAME** **DATE**

Erich Hirsch D.D.S.

Erich Hirsch, DDS, P.C.
7045 Veterans Blvd, Suite A1
Burr Ridge, IL 60527

(708) 354-0835 BurrRidgeDentist.com

Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept strictly confidential.

Have you taken any prescription drugs during the last 6 months? Please list. _____ **YES NO**

_____

_____

Are you taking any over the counter medications or herbal supplements? Please list. _____ **YES NO**

_____

Are you allergic to (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by any medication? _____ **YES NO**

Please list _____

Any surgeries and/or hospitalizations? _____ **YES NO**

Have you ever had any excessive bleeding requiring special treatment? _____ **YES NO**

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? _____ **YES NO**

Have you ever been told to take antibiotics prior to dental treatment? _____ **YES NO**

Use of alcohol: **YES NO | DAILY WEEKLY MONTHLY** Use of recreational drugs: **YES NO**

Do you use tobacco? What type and how much per day? _____ **YES NO**

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

LOW BLOOD PRESSURE	**KIDNEY PROBLEMS**	**DIABETES TYPE I OR II**	**ANEMIA**
HIGH BIOOD PRESSURE	**CANCER**	**BLOOD THINNERS**	**EATING DISORDERS**
HEART DISEASE / ATTACK	**SEXUALLY TRANSMITTED DISEASES**	**THYROID / GLAND PROBLEMS**	**LEUKEMIA**
ANGINA PECTORIS	**ACID REFLUX**	**SEIZURES / EPILEPSY**	**BRUISE/BLEED EASILY**
ARTIFICIAL HEART VALVE	**ULCERS**	**ALLERGIES / SINUS TROUBLE**	**OSTEOPOROSIS**
STROKE	**LIVER FAILURE**	**ASTHMA / BRONCHITIS**	**ARTHRITIS**
HEART PACEMAKER	**HEPATITIS / JAUNDICE**	**EMPHYSEMA / COPD**	**HEART SURGERY**
RADIATION TREATMENT	**HEART FAILURE**	**CHEMOTHERAPY**	**AUTO-IMMUNE DISEASE**

Are you pregnant now? **YES NO**	Practicing birth control? **YES NO**	Plan to become pregnant? **YES NO**

Emergency Contact _____ Relation _____ Emergency Phone_____

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

_____

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Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or chewing?	YES	NO
Have you noticed any mouth odors or bad taste?	YES	NO
Do you frequently get cold sores?	YES	NO
Do you frequently get oral ulcers?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have you noticed any loose teeth?	YES	NO
Have your teeth shifted over the years?	YES	NO
Does food tend to become caught in between your teeth?	YES	NO

DO YOU:

Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	YES	NO
Have a hard time opening wide?	YES	NO
Mouth breathe while awake or asleep?	YES	NO
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	YES	NO

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Clicking or popping of the jaw?	YES	NO
Pain in the jaw joint area near the ear?	YES	NO
Difficulty in opening or closing your mouth?	YES	NO
Headaches, neck aches, or shoulder aches frequently?	YES	NO
Sore muscles in the neck or shoulders?	YES	NO

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays?_____ How often do you have dental examinations ? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric brushes, toothpick, etc.) _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____

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Notice Of Privacy Practices

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).

Acknowledgment Of Receipt Of Notice Of Privacy Practices

(You May Refuse to Sign This Acknowledgment)

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

_____

_____
PRINT NAME

_____ _____
SIGNATURE OF PATIENT SIGNATURE OF LEGAL GUARDIAN

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship.

_____

_____

****

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

____ It was emergency treatment

____ I could not communicate with the patient

____ The patient refused to sign

____ The patient was unable to sign because _____

____ Other (please describe) _____

Responsible Party _____ *Date:* _____

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Financial Policy

Updated 8/31/2023

Patient Name: _____

Erich Hirsch DDS is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fee's, Financial Policy, or your responsibility.

- All Patients Must Complete Our "Patient Information Form" Before Seeing the Dental Professional.
- Erich Hirsch DDS Provides Insurance Company Billing as A Courtesy to Our Patients.
  The Patient Portion of Particular Dental Service(s) Is Estimated and Due at the Time of Service.
- Full Payment Is Due at The Time of Service.
- We Accept Cash, Checks, Visa, Master Card, American Express, Discover, and Care Credit.

INSURANCE

Erich Hirsch DDS provides insurance company billing as a courtesy to our patients. The patient portion of service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the number of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations you will be responsible for the full number of dental services that exceed the plan's limitations. You as a patient are always responsible for any charges that are not covered by your insurance. A statement will be sent to the patient for any balance which is not paid by the insurance company. Patients are responsible for payment in full after 45 days of treatment, regardless of any delay in payments by their insurance company.

MEDICARE/MEDICAID/WORKER' SCOMPENSATION

If you are covered by Medicare, Medicaid or Worker's Compensation, please discuss your payment situation with our office staff prior to your initial appointment with Erich Hirsch DDS

DELINQUENT PAYMENTS

All payment's returned due to non-sufficient funds will be subject to a NSF fee of $35.00. Account balance's outstanding for a period of over 90days without an arranged payment plan will be turned over to an outside collection company for further processing. Any account that is forwarded to an outside collection company will no longer be considered "In Good Standing" and all patients on the account will be dismissed from the practice.

MISSED APPOINTMENTS

In lieu of charging a missed appointment fee, any appointment not confirmed within 24 business hours will beautomati cally cancelled by our software system. The only exception to this rule will be for patients that either fail (no show) for their appointment or cancel within 4 hours of their scheduled appointment time. These patients will be charged a $45 cancellation fee, as a cancellation within this time frame is usually not an adequate amount of time for someone who has been waiting on the cancellation list to be able to accept an appointment. Please help us to serve you, as well as our patients who are waiting on our cancellation list better, by confirming your appointments as soon as possible.
Erich Hirsch DDS reserves the right to charge a deposit for scheduling an appointment to any patient that we feel has abused the offices scheduling policy.

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

Responsible Party _____ *Date:* _____

Erich Hirsch DDS