SK DENTAL ASSOCIATES, P.C.
495 Route 47 Sugar Grove, IL 60554Ph: 630-466-1100Fax: 630-466-7933

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender:_____Family Status: _____Drivers License#_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment e-mail address

_____
City State Zip Code

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

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

☐ AIDS
☐ Allergies
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. In the even of default, I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an additional 50% of the balance, added for collection costs.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I hereby authorize the doctor to take radiographs or any other diagnostic aids deemed appropriate by the doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies a certain risk.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

SK DENTAL ASSOCIATES, P.C.
495 Route 47, Sugar Grove IL 60554
T: (630)466-1100F: (630)466-7933

FINANCIAL POLICY

Due to the rising costs of billing and delay with which insurance companies pay their claims, we must adhere to our financial policy. You should expect to pay for treatment (your portion or co-payment) each time you come to the office, unless previous financial arrangements have been made in writing. For your convenience, we accept **PERSONAL CHECKS, CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS** and **FINANCING** for those who qualify. If you are interested in financing, please ask for more details.

We thank you for choosing us as your dental health care provider. We are committed to quality dental care for you and your family. Your clear understanding of our financial policy is vital to our professional relationship. Please speak with someone in our office if you have any questions about this policy.

We charge what is usual and customary for the quality services we provide. Your insurance company may have a sliding scale that may not reflect charges in the area. However, if we are contracted with your insurance company as a provider, we are bound by their fee schedule.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

Your responsibility is to pay your portion or co-payment **AT THE TIME OF SERVICE** and providing timely, accurate and complete insurance information to our office. Please make sure we always have your current and up-to-date information so that we may accurately file your claims.

As a courtesy and convenience to you, we would be happy to bill your insurance company for any balance due by your insurance, but you need to pay your portions such as co-payments, deductibles, non-covered services etc**, AT THE TIME OF SERVICE.**

If you do not carry any dental insurance coverage, you are required to pay in full **AT THE TIME SERVICES ARE RENDERED**, unless previous financial arrangements have been made in writing.

Since it is impossible to know all individual insurance policies, it is your responsibility to contact your insurance company if you have any concerns as to whether a charge is covered and at what percentage. We are able to provide **ESTIMATES** of your portion at the time of service, but should a difference in amounts arise, you will be billed the remaining balance.

I have read the above financial policy and I agree to the terms listed above.

PATIENT NAME: _____
(Please print)

PATIENT SIGNATURE: _____ **DATE:**_____

Parent/ Guardian/ Financially responsible party signature: _____

RELATIONSHIP TO PATIENT: _____