Leila Soltani, D.D.S., M.S. (Periodontics, Laser & Implant Dentistry)
2312 Plainfield Rd. Crest Hill, Illinois 60403 (815) 744-7175

Dental History Questionnaire

Last _____ First _____ Middle _____

Name of your general dentist? _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time?..... Yes No
2. How may we help you?

3. What condition would you like your oral health to be in ten years from now?

4. Date of last dental visit?
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No

Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes	No	Shifting in bite?	Yes	No
Unpleasant taste/bad breath?	Yes	No	Change in bite?	Yes	No
Swelling/lumps in mouth?	Yes	No	Burning tongue/lips?	Yes	No
Orthodontic treatment (braces?)	Yes	No	Frequent blister, lips/mouth?	Yes	No
Clenching/grinding?	Yes	No	Sensitive teeth (hot or cold?)	Yes	No
When			Sensitive to sweets?	Yes	No
Clicking/popping jaw?	Yes	No	Sensitive to biting?	Yes	No
Difficulty opening or closing jaw?	Yes	No	Food Impaction?	Yes	No
Loose teeth?	Yes	No	Biting cheeks/lips?	Yes	No

Do you use the following?

Toothbrush Yes No How Often Proxabrush? Yes No
Toothbrush type is: Soft Medium Hard
Dental Floss? Yes No How Often
Does dental treatment make you nervous? Yes No Slightly Moderately Extremely
If so what:
Etc:

Circle one:

1. Please evaluate the importance of your teeth: (1-10, 10 being highest) ____
2. What level of health do you think your current oral health is in? (1-10, 10 being highest) ____
3. Is there anything about your teeth you would like to change? If so please list.

4. Please rank the following options in the order in which they would prevent you from having dental treatment. (1-4, 1 being the highest) Fear of pain ____ Lack of concern ____ Cost of treatment____ Missing work time ____
5. Have you had any positive dental experiences?

6. Have you had any negative dental experiences?

7. Is there anything you would like to know about our office?

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Medical History Form

Referred By_____ **Date** _____

Patient E-mail address: _____ **Home Phone**_____

Name _____ **Cell Phone** _____
Last First Middle

Home Address_____ **Business Phone** _____

City _____ **State** _____ **Zip Code**_____

Employer_____ **Job Title**_____ **SS#**_____

Date of Birth _____ **Sex** M F **Height**_____ **Weight**_____

Name of Spouse _____ **Closest Relative**_____ **Phone :**_____

If you are completing this form for another person, your relationship to that person is?_____

Your answers to the following questions are for our records only and are considered confidential. You may be questioned during your visit on your response to the questions you answered.

1. Are you in Good health?	Yes	No
2. Have there been changes in your general health in the past year?	Yes	No
3. Physician: Name: Address:		
4. Last Physical Exam _____ Did you have blood drawn at this physical?	Yes	No
5. Are you now under the care of your physician? If so what is the condition being treated?	Yes	No
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Please explain:	Yes	No
7. List any medications – prescription or non-prescription that you are currently taking:		
8. Are you on Aspirin Therapy?	Yes	No
9. Are you on Vitamin E Therapy?	Yes	No
10. Have you taken or are you taking Bisphosphonates (Fosamax, Actonel, Boniva, Didronel)? Please list which one & how long you've been taking:	Yes	No
11. Do you smoke? If yes, how long have you smoked? _____ How many packs per day? _____	Yes	No
12. Do you have a family history of periodontal disease?	Yes	No

Do you have or had any of the following diseases or problems:

1. Damaged or artificial heart valves?	Yes	No
2. Heart murmur or rheumatic heart disease?	Yes	No
3. Cardiovascular disease (heart trouble, heart attack, angina, coronary, insufficiency, coronary occlusion, stroke or arteriosclerosis?	Yes	No
4. High Blood Pressure?	Yes	No
5. Chest pain upon exertion?	Yes	No
6. Shortness of breath after mild exercise or when lying down?	Yes	No
7. Do you have inborn heart defects?	Yes	No
8. Cardiac pacemaker?	Yes	No
9. Seasonal Allergies?	Yes	No
10. Sinus trouble?	Yes	No
11. Asthma or hay fever?	Yes	No
12. Fainting or seizures?	Yes	No
13. Persistent diarrhea or weight loss?	Yes	No

14. Diabetes Yes No Controlled? Yes No Blood Sugar Level: _____ Date: _____
15. Hepatitis, Jaundice, or liver disease? Yes No
16. Aids or HIV infection? Yes No
17. Thyroid problems? Yes No
18. Respiratory problems, emphysema, bronchitis etc? Yes No
19. Arthritis or painful swollen joints? Yes No
20. Stomach ulcer or hyperacidity? Yes No
21. Kidney trouble? Yes No
22. Tuberculosis? Yes No
23. Persistent cough, cough that produces blood or persistent swollen glands in neck? Yes No
24. Low blood pressure? Yes No
25. Sexually transmitted disease? Yes No
26. Epilepsy? Yes No
27. Problems with mental health? Yes No
28. Cancer? Yes No
    What Type? _____ Treatment Received? _____
29. Problems of the immune system? Yes No
30. Abnormal bleeding? Yes No
31. Blood transfusion? Yes No
32. Blood disorder such as anemia? Yes No
33. Any treatment for tumor or growth? Yes No

Are you allergic or have you had a reaction to:

1. Latex Allergy? Yes No
2. Local anesthetic? Yes No
3. Penicillin or other antibiotics? Yes No
4. Sulfa drugs? Yes No
5. Barbiturates, sedatives, or sleeping pills? Yes No
6. Aspirin? Yes No
7. Iodine? Yes No
8. Codeine or other narcotics? Yes No
9. Other?

General Information

1. Do you have any disease, conditions, or problems not listed you think I should know about? Yes No
   Explain:

2. Are you wearing contact lenses? Yes No
3. Are you wearing removable dental appliances? Yes No

Women

1. Are you pregnant? Yes No
2. Are you nursing? Yes No
3. Are you taking birth control pills? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by dentist:

Comments on patient interview concerning medical history

_____

Date: _____ **Signature of Dentist:** _____

Pharmacy Name:_____ **Pharmacy Phone:** _____

RESPONSIBLE PARTY INFORMATION

Complete this form if the Responsible Party (person financially responsible for account) is someone other than the patient, or if the patient is under 18. If the patient IS the Responsible party, please write "self" under "Name of person responsible for the account."

Name of person responsible for the account _____

Relationship to patient _____

Social security number _____

Date of birth _____

Street address _____

City_____

State _____

Zip code _____

Contact phone number _____

DENTAL INSURANCE

Primary Company_____ Group _____

Insurance address_____

Insurance phone #_____

I.D. Number from Insurance card (Required) _____
(if your insurance card has no ID number listed enter your social security number)

Subscriber_____

Relationship to patient_____ Date of Birth _____

Subscriber's Employer_____

Employer's Address (City, State, and Phone #) _____

Your signature is necessary for us to process all insurance claims, to ensure payment for services rendered, and to release medical information to other providers, when necessary, for treatment.

I authorize the release of certain protected health information (PHI) about me when necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical\dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled to Leila Soltani, D.D.S., M.S. This assignment will remain in effect until revoked by me in writing or expire on date of completed treatment. A photocopy of this assignment is to be considered as valid as the original.
By signing this form, you hereby accept responsibility to pay your estimated insurance co-payment at the time of service.

X Signature of Patient_____**Date**_____
Parent or legal guardian

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____

{Signature of Patient and/or Guardian} {Date}_____

{Relationship to Patient} Self or Other: _____

I, _____, acknowledge and allow Leila Soltani, DDS, MS, PC- Leila Soltani, D.D.S. & Thomas B. Braun, D.D.S to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call [ ] my home phone [ ] my work number [ ] my cell number

_____ _____ _____

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR

[ ] you may e-mail me at _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

OFFICE GUIDELINES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.
Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Guidelines. **We require you to read and sign this prior to any further treatment.** All patients must complete our information and insurance form before seeing the doctor.

1. Full payment is due at the time of service (unless previous arrangements have been made).
2. We accept cash, checks, or Visa//MasterCard/American Express/Discover.
3. We offer an extended payment plan with prior credit approval.
4. Although we hope that this never happens but should your account have to go to collections you will be fully liable for all collection costs, including court costs and attorney fees.

Regarding Insurance

We may accept assignment of your insurance benefits in the event of active therapy. However, we do require you to pay the percent that your insurance company doesn't pay at the time of service. We can do a pre-estimate with the insurance to know what they will pay. The balance is your responsibility whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.** If your insurance company has not paid your account in full within 60 days, the balance will automatically be your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your insurance policy.

Maintenance Patients with Insurance

Payment is due in full at the time of service; we will file your insurance claim and have them reimburse you.

Work/School Appointments

It is impossible for Dr. Braun and or Dr. Soltani to see all of his/her patients outside of usual working/school (9-5) hours. Some appointments will have to be scheduled during these hours.

Minor Patients

The adult accompanying a minor and the parent (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/American Express/Discover, or payment by cash or check at the time of service.

Missed Appointments

Unless cancelled/rescheduled at least **24 hours in advance**, our policy is to charge for missed surgery appointments at the rate of **$150.00** per scheduled hour and **$75** for missed Hygiene appointments. Pre-payment for sedation is due 1 week prior to any surgery. This is non-refundable if cancelled with less than 5 business day notice. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.

I have read, understand and agree to these Office Guidelines.

X_____ Date_____
Signature of Patient (if 18 years or older), or Guardian