



# DeWitt-Piatt

Bi-County Health Department

PREVENT • PROMOTE • PROTECT

www.dewittpiatthealth.com

## PATIENT REGISTRATION for Dental Clinic

### Patient Information:

Today's date \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_

If prefer another name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone No. \_\_\_\_\_

Employer Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Birth date \_\_\_\_\_

Emergency Contact name \_\_\_\_\_ Phone No. \_\_\_\_\_

Best way to contact you: \_\_\_\_\_ Cell phone \_\_\_\_\_ Home phone \_\_\_\_\_ Text

\_\_\_\_\_ Email If yes, email address \_\_\_\_\_

### Parent/Guardian Information if patient is child under 18:

Name of Parent/Guardian \_\_\_\_\_ Birth date \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone No. \_\_\_\_\_

### Insurance Information:

#### *Primary Insurance (please provide card to copy)*

Name of Insured \_\_\_\_\_ Employer \_\_\_\_\_

Name of Dental Insurance Co. \_\_\_\_\_

Member No. \_\_\_\_\_ Group No. \_\_\_\_\_

Address to send claims to \_\_\_\_\_

#### *Secondary Insurance (please provide card to copy)*

Name of Insured \_\_\_\_\_ Employer \_\_\_\_\_

Name of Dental Insurance Co. \_\_\_\_\_

Member No. \_\_\_\_\_ Group No. \_\_\_\_\_

Address to send claims to \_\_\_\_\_

## **Policies**

### **Appointment Reminders:**

We may call, text, or write to remind you of scheduled appointments, or that it is time to make a routine appointment. *Unless you tell us otherwise, we will mail you an appointment reminder, and/or leave you a reminder message including the date of appointment, time of appointment and name of the patient on the mailbox of the phone number or the address you have given us. Please keep us up to date of any phone number and/or address changes.*

### **Appointment Cancellation/Broken Policy:**

Due to the large number of people who make appointments but fail to show up for them or fail to give adequate notice when cancelling them, it has become necessary to have a policy on appointment responsibility. **An appointment is considered broken or missed if the patient fails to show up for the appointment, if the patient appears more than 10 minutes late for a scheduled appointment, or if the patient calls to cancel an appointment with too little advance notice to allow that appointment time to be rescheduled with another patient.** After the FIRST missed appointment there may be a waiting period before scheduling a second appointment. A SECOND failed appointment may prevent you from receiving dental treatments in our clinic. You will receive notification by mail if we find it necessary to take this action. We reserve the right to decide if this policy can be waived for special situations. No action will be taken against patients who have cancelled their appointments at least 24 hours in advance.

### **Dental Room Policy:**

A parent or guardian is allowed with a child who is 18 years of age or under. Due to the limited space in the dental rooms we request that all patients over the age of 18 please be seen alone unless a special request has been granted by the attending dentist. No more than 1 person may accompany someone else during a dental treatment such as an extraction or filling. Safety of your family is a concern of the health department so unless a child is being seen by the dentist or hygienist we request he/she stay in the waiting room with another adult. *We also ask that all cell phones be turned off during procedures and no foul language be used.*

### **Special Needs:**

Please make us aware of any special needs you or your child may have. We will try to accommodate your needs within reason to make your visit to the dental clinic as worry-free as possible. Examples include: wearing headphones during procedures, having extra back support in the chair, changing the music station. Ultimately treatment will depend upon the cooperation level of you or your child. If we are unable to provide you with treatment, we will provide you with your insurance phone number to call or a list of other providers.

### **Restorations (Fillings):**

Please be aware that care must be exercised in chewing on fillings in order to avoid breakage or soft tissue damage. Also, a more extensive filling than originally diagnosed may be required due to additional decay. Sensitivity may occur after a newly placed filling and may last for several weeks. It is the discretion of the dentist to use a silver colored filling (amalgam) or a white colored filling (composite) for durability reasons for posterior (back) teeth. Front teeth will always have white colored fillings.

**Possible complications from procedures:**

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reactions to injections, changes in occlusion (biting), jaw muscle cramps or spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure.

**X-rays and photos:**

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the Dental staff with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. If you request an x-ray be sent by email to another provider, we will do all we can to protect your information; however, we do not use encrypted email so a risk still remains. If you request, a copy can be printed instead for you to pick up.

**Dismissal from the Dental Clinic:**

Patients may be dismissed from the practice at the discretion of the Dewitt-Piatt Bi-County Health Dept. Dental Clinic staff. Reasons for dismissal include, but are not limited to:

- *More than 2 times, being more than 15 minutes late to an appointment.*
- *More than 2 times, failure to give a 24-hour advance notice to cancel a scheduled appointment.*
- *Refusal to cooperate and work with the dental staff.*
- *Threatening, inappropriate or rude behavior*
- *Failure to pay an outstanding balance.*

**Payment for Services Including patients with Dental Insurance or Medicaid:**

- We accept most major dental insurance plans along with Illinois Medicaid, IL State All Kids Program and their associated managed care companies. A patient will be required to bring his/her current Medicaid and insurance cards to each visit.
- Not all benefits covered by the Medicaid card or private insurance companies are offered by our practice. A referral may be needed for further treatment.
- All of a patient's dental needs may not be covered by the Medicaid card or private insurance, either because it is not a benefit or because of benefit limitations. Our office has no control over what is covered or not by insurance. The patient is financially responsible for all services that are received that are not covered by the Medicaid card or private insurance and full payment is expected at the time of service.
- Patients with an outstanding balance for dental work provided will not be seen until all balances are paid in full. Absolutely no exceptions will be made.
- All insurance co-pays and patient portions are due at the time of service.

**Consent for Services**

By signing this form, I agree to the following:

- To allow the dental staff of DeWitt-Piatt Bi-County Health Department Dental Clinic to proceed with and perform any exams, x-rays, dental cleanings, restorations, and treatments as explained to me and found to be necessary for my (my child's) care.
- That I have the right to ask questions before any procedure for myself or my child.
- To follow all policies as dictated by the DeWitt-Piatt Bi-County Health Department in the section entitled "Policies."
- That I understand that dentistry is not an exact science and that any treatment plan provided will be an estimate of care and subject to modification depending upon unforeseen or undiagnosable circumstances that may arise during the course of treatment.
- That I understand that after payment or non-payment by my dental insurance I am responsible for all non-covered fees for myself or my child as legal guardian. I, agree to pay any collection fees, or court costs that may be incurred to satisfy this obligation.

\_\_\_\_\_  
**Patient, Parent or Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

**Authorization for Release of Records**

I authorize the DeWitt-Piatt Bi-County Health Dept. Dental Clinic to release my or my child's information including diagnosis and the records of treatment to my or my child's insurance company in order to receive payment or for referral of services to another specialty provider. I authorize the DeWitt-Piatt Bi-County Health Dept. Dental Clinic to release my or my child's information including diagnosis and the records of treatment to my or my child's health practitioners or specialists for best treatment of care.

I authorize the DeWitt-Piatt Bi-County Health Dept. Dental Clinic to release my or my child's information including diagnosis and the records of treatment to the following people either by phone or in person. For my child I allow the following person(s) to serve as a proxy when bringing my child for appointments by allowing decisions to be made without my presence for preventive and restorative procedures only: (Please include spouse since we cannot release information without this consent.)

\_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
**Patient, Parent or Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

**Notice of Privacy Practices and Disclosures**

I, also hereby acknowledge that I received or was offered a copy of the "Notice of Privacy Practices" from DeWitt-Piatt Bi-County Health Dept. Dental Clinic dated December 28, 2023.

\_\_\_\_\_  
**Patient, Parent or Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

## Dental and Medical History Information

Please understand that it is important that you release any information about your medical history to your dentist. Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. It is important that you inform us of any medications that you are taking each time that you come to an appointment, as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics, etc.

Please be sure to provide us with a list of any drug allergies you may have. Thank you!

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### Dental History:

Please list dental concerns \_\_\_\_\_

Are you in pain? \_\_\_\_\_ Yes \_\_\_\_\_ No Where: \_\_\_\_\_

Sensitive to Hot? \_\_\_\_\_ Yes \_\_\_\_\_ No Sensitive to Cold? \_\_\_\_\_ Yes \_\_\_\_\_ No

Brush daily? \_\_\_\_\_ Yes \_\_\_\_\_ No Floss daily? \_\_\_\_\_ Yes \_\_\_\_\_ No

Gums ever bleed? \_\_\_\_\_ Yes \_\_\_\_\_ No Loose/moveable teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Clench/grind? \_\_\_\_\_ Yes \_\_\_\_\_ No Popping/clicking in jaw? \_\_\_\_\_ Yes \_\_\_\_\_ No

Wear a partial? \_\_\_\_\_ Yes \_\_\_\_\_ No Periodontal disease? \_\_\_\_\_ Yes \_\_\_\_\_ No

Estimated date of last dental visit \_\_\_\_\_

### Medical History:

Please list the name of your primary care/family doctor \_\_\_\_\_

Have you ever been hospitalized or had a major operation? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what for: \_\_\_\_\_

Have you ever had a serious head or neck injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had a **joint replacement** (hip, knee, wrist) or an artificial heart valve?

\_\_\_\_\_ Yes \_\_\_\_\_ No Type: \_\_\_\_\_ Year: \_\_\_\_\_

Has your doctor ever recommended you **pre-medicate** with antibiotics before dental work?

\_\_\_\_\_ Yes \_\_\_\_\_ No Reason: \_\_\_\_\_

Have you ever taken Fosamax, Boniva, or any other bisphosphonates? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you are on a special diet, please list the type: \_\_\_\_\_

Do you smoke, vape or use smokeless tobacco? If yes, list type/amount? \_\_\_\_\_

Are you taking oral contraceptives? \_\_\_\_\_ Yes \_\_\_\_\_ No (Antibiotics may change effectiveness)

Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, due date: \_\_\_\_\_

Are you currently taking any **blood thinners** such as Coumadin, Warfarin, Plavix or a low dose Aspirin? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, type: \_\_\_\_\_

**PLEASE FLIP OVER TO COMPLETE MEDICAL HISTORY**

**Current Medications: (a copy can be made of any lists)**

**Allergies:**

- |                                    |   |                                   |  |
|------------------------------------|---|-----------------------------------|--|
| <input type="checkbox"/> Acrylic   | <input type="checkbox"/> Amoxicillin/Penicillin | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Codeine           |
| <input type="checkbox"/> Food Dyes | <input type="checkbox"/> Ibuprofen              | <input type="checkbox"/> Latex    | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Metal     | <input type="checkbox"/> Sulfa Drugs            | <input type="checkbox"/> Tramadol |  |

List any other allergies: \_\_\_\_\_

**Do you have, or have you had, any of the following? (Please check those that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive                       | <input type="checkbox"/> Alzheimer's Disease/Dementia   | <input type="checkbox"/> Anaphylaxis               |
| <input type="checkbox"/> Anemia                                  | <input type="checkbox"/> Angina/Chest pain  | <input type="checkbox"/> Anxiety                   |
| <input type="checkbox"/> Arthritis                               | <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Attention Disorder (ADHD/ADD)           | <input type="checkbox"/> Autism   | <input type="checkbox"/> Autoimmune Disease        |
| <input type="checkbox"/> Blood Disease                           | <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Breathing problems        |
| <input type="checkbox"/> Bruise Easily                           | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Congenital Heart Disorder               | <input type="checkbox"/> Convulsions  | <input type="checkbox"/> Crohn's Disease           |
| <input type="checkbox"/> Depression                              | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Dizziness                 |
| <input type="checkbox"/> Drug Addiction                          | <input type="checkbox"/> Dry Mouth  | <input type="checkbox"/> Easily Winded             |
| <input type="checkbox"/> Eating Disorder                         | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Epilepsy or Seizures      |
| <input type="checkbox"/> Excessive Bleeding                      | <input type="checkbox"/> Excessive Thirst   | <input type="checkbox"/> Fainting spells           |
| <input type="checkbox"/> Frequent Cough                          | <input type="checkbox"/> Frequent Diarrhea  | <input type="checkbox"/> Frequent Headaches        |
| <input type="checkbox"/> Frequent Heartburn/GERD                 | <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Heart Attack/Failure      |
| <input type="checkbox"/> Heart Murmur/Irregular heartbeat        | <input type="checkbox"/> Heart Pacemaker  | <input type="checkbox"/> Heart Trouble/Disease     |
| <input type="checkbox"/> Hemophilia/Bleeding disorder            | <input type="checkbox"/> Hepatitis A  | <input type="checkbox"/> Hepatitis B               |
| <input type="checkbox"/> Hepatitis C                             | <input type="checkbox"/> Herpes   | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> High Cholesterol                        | <input type="checkbox"/> Hives/Rash   | <input type="checkbox"/> Hypoglycemia              |
| <input type="checkbox"/> Kidney Problems                         | <input type="checkbox"/> Leukemia   | <input type="checkbox"/> Liquid Iron Supplements   |
| <input type="checkbox"/> Liver Disease                           | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Lung Disease              |
| <input type="checkbox"/> Lupus                                   | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> MRSA                      |
| <input type="checkbox"/> Oppositional Defiance Disorder          | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Pain in Jaw Joints/TMD    |
| <input type="checkbox"/> Parathyroid Disease                     | <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)  |  |
| <input type="checkbox"/> Prolonged use of Corticosteroids        | <input type="checkbox"/> Radiation/Chemotherapy   | <input type="checkbox"/> Recent Weight Change      |
| <input type="checkbox"/> Renal Dialysis                          | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Sensory Processing sensitivity/disorder | If yes, to: <input type="checkbox"/> Noises <input type="checkbox"/> Smells <input type="checkbox"/> Sounds <input type="checkbox"/> Tastes |  |
| <input type="checkbox"/> Shingles                                | <input type="checkbox"/> Sickle Cell Disease  | <input type="checkbox"/> Sinus Trouble             |
| <input type="checkbox"/> Sjogren's Syndrome                      | <input type="checkbox"/> Stomach/Intestinal Disease   | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Swelling of Limbs                       | <input type="checkbox"/> Thyroid Disease  | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Tuberculosis                            | <input type="checkbox"/> Tumors or growths  | <input type="checkbox"/> Ulcers                    |

Any other illnesses: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date completed:** \_\_\_\_\_