David P Potts D.D.S., Ltd.
libertyvilledentist.com
team1@libertyvilledentist.com
Lake County Dental Care | 908 S. Milwaukee Ave. • Libertyville, IL 60048-3229
(847)362-6540

Welcome to Lake County Dental Care

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: __________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ______________________________ **Best time to call:** ____________

Phone: __________ __________ __________ ______ __________ __________
Home Mobile Work Ext Fax Other

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

I prefer to be contact by

☐ Cell Phone ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

____

In an emergency, who should be notified? Please enter name, phone number, and relationship below

____

____

Employer Name

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________________ **Phone:** ____________

Employer Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Insurance Subscriber and/or Parent/Guardian Information

This ONLY needs to be filled out if the insurance subscriber is other than the patient AND/OR you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **DL#:** ______________________

Email Address: ______________________________ **Best time to call:** ______________

Phone: __________ __________ __________ ______ __________ __________
Home Mobile Work Ext Fax Other

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Primary Dental Insurance

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ______________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Do you have secondary dental insurance? ◯ Yes ◯ No

Dental History

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

____

____

Approximate date of most recent dental exam and/or dental x-rays

____

____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

____

____

Is there anything about the appearance of your smile that you would like to change?

____

____

Check all that apply

- ☐ Do you have any dental treatment planned?
- ☐ Have you been told that you have periodontal (gum) disease?
- ☐ Have you ever had oral surgery?
- ☐ Have you lost any permanent adult teeth?
- ☐ Have the lost teeth been replaced?
- ☐ Have you had braces or orthodontic treatment?
- ☐ Have you had extensive dental treatment?
- ☐ Is any part of your mouth sensitive to temperature, pressure, food, or drink?
- ☐ Do you wear dentures or partials?

If any of the checked boxes need further explanation, please describe:

____

____

____

Health History

Indicate which of the following you have had or have at present.
By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Alcohol Abuse
- ☐ Asthma
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Atrial Fibrillation
- ☐ Auto Immune Disease
- ☐ Arthritis
- ☐ Artificial Prosthesis
- ☐ Back Pain
- ☐ Been advised not to take any medications
- ☐ Blood Disease
- ☐ Cancer/Tumor/Growth
- ☐ Chest Pain or Shortness of Breath
- ☐ Diabetes - Type 1 or Type 2
- ☐ Defibrillator Implant
- ☐ Difficulty Swallowing
- ☐ Dizziness/Fainting
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Facial Pain/Pressure
- ☐ Feeling of something stuck in your throat
- ☐ Frequent Headaches or Migraines
- ☐ Glaucoma
- ☐ Head or Neck Injuries
- ☐ Heart Attack or Stroke
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Medically Supervised Diet
- ☐ Meningitis
- ☐ Menopause
- ☐ Mental Health Disorders
- ☐ Methadone
- ☐ Mitral Valve Prolaps
- ☐ Osteoporosis
- ☐ Other
- ☐ Pacemaker/Stents
- ☐ Pregnant
- ☐ Prostate Disorder
- ☐ Radiation/Chemotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Regularly Take Pain Reliever
- ☐ Recent Hospitalization (illness or injury)
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Substance Abuse
- ☐ Tobacco Use
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Presently being treated for any other illness
- ☐ Tobacco Use

Do you have Allergies to any of the following?

☐ Augmentin ☐ Sulfa ☐ Bactrim ☐ Iodine ☐ Vicodin ☐ Codeine ☐ Latex ☐ Erythromycin ☐ Penicillin

Please explain any conditions you marked above.

____

____

Are you presently being treated for any other illnesses? If yes, please explain.

____

____

Do you take any antibiotic premeditation prior to dental visits? If yes, please explain.

____

____

What is the name of your physician and the date of your last physical?

____

____

Describe any current medical treatment, impending surgery, or other treatment that may affect your dental treatment.

____

____

List all your medications. Include prescription, non-prescription. aspirin, and herbal supplements.

____

____

____

Is there any additional information you would like the Doctor to be aware of?

____

____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions and alerts on this health history and responded accordingly. There are no other medical conditions, medications, or allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

TMJ History

Check all that apply:

- ☐ Do you ever have a burning or painful sensation in your mouth?
- ☐ Do you get popping, clicking, or grinding noises when you open or close your mouth?
- ☐ Do you have difficulty chewing?
- ☐ Do you ever wake up with an awareness of your teeth or jaws?
- ☐ Have you ever been told you grind your teeth while you sleep?
- ☐ Are you aware of clenching your teeth during the daytime?
- ☐ Do you have trouble opening your mouth widely?
- ☐ Does your jaw ever lock open or closed?
- ☐ Do you feel your bite is different, unstable, or uncomfortable?
- ☐ Have you sought treatment for TMJ, headaches, or pain?

Do you currently or have you ever had pain in any of the following areas?

☐ Jaw ☐ Ear ☐ Face ☐ Neck ☐ Teeth ☐ Head

If any of the checked boxes need further explanation, please describe:

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Consent for Treatment

I hereby authorize Lake County Dental Care and designated team members to take x-rays, study models, photographs, electro-diagnostic studies, and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize Lake County Dental Care and the designated team members to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide me with proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program, and ongoing progress report to any referring dentist, physician, chiropractor, or other health care professionals as indicated on the following page. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims.

Consent for Financial Policy

Payment is expected the day of your procedure as outlined verbally and/or in the written financial arrangement. We accept cash, check, MasterCard/Visa, American Express, and Discover. For our patients carrying medical insurance, we do not accept assignment of benefits. However, we are happy to assist you with your insurance billing as a courtesy, though financial responsibility lies with you. Please ask our Patient Care Coordinators about your insurance issues.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed, I understand that a late charge of 2% on monthly balances will be added to my account and my account may be turned over for legal collection of any overdue amount. I understand that a credit history may be secured. Our returned check fee is $25.

Our goal is to eliminate billing surprises, so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

Appointments

Should you need to cancel an appointment we ask that you notify our office at least 2 business days in advance. If you fail to cancel your appointment appropriately, or do not show up for your scheduled appointment, you will be charged a broken appointment fee of $75.

☐ ***By checking this box, I acknowledge that I have read and understand the Lake County Dental Care Consent for Treatment, Financial, and Appointment policies. I have had all of my questions regarding these issues answered by a Patient Coordinator and agree to abide by these policies.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Response Date: * ____________

HIPAA Acknowledgment

This notice of privacy practices describes how we may use and disclose your protected health information and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that related to your past, present, and future physical, dental, or mental health conditions and related health care services. Your protected health information may be used and disclosed by your dentist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist's practice, and any other use by law. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.
We will also disclose to a family member, spouse, and adult children any information as necessary for your overall dental care. By signing this document you give permission to share your dental health information with any family member, friend, or other persons to the extent necessary to help with your healthcare and/or with payment of your healthcare. Your protected health information will be used as needed to obtain payment for your health and dental care services, including your family members or friends. We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical/dental students, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Public Health Issues, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation Services, Research, Criminal Activity, Military Activity, National Security, and Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You have the right to inspect and copy your protected health information under federal law. However, you may not inspect or copy the following records; notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You may ask us not to use or disclose any part or your protected health information for the purposes of treatment, payment, or healthcare operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing. Your dentist is not required to agree to a restriction that you may request. If your dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling a complaint. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA compliance Officer in person or by phone at our main phone number. (847)362-6540

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

____

____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: ____/____/________