PINGREE SMILE CENTER
CREATING HEALTHY SMILES.....STARTING WITH YOURS!

2401 West Route 20, Unit #103
Pingree Grove, IL 60140
(847) 462-4330
info@pingreesmilecenter.com

Welcome to Pingree Smile Center! Thank you for choosing us for your dental needs. We look forward to developing a relationship with you.

Enclosed you will find registration forms that we need to assemble information for your chart. We will need a photo ID, such as a driver's license, and any dental insurance cards.

Please notify us if you have secondary dental insurance.

INSURANCE AND FINANCING

If you plan on using your dental insurance, you may want to review your benefit book to better understand your coverage, because each plan is different. We are happy to review your plan with you if you have questions. As a courtesy, we will file your claim for you.

Please be prepared to pay your co-pay and/or any deductible at the time of service.

We also require your authorization to receive payments from your insurance company. Your signature below will authorize direct payment of insurance benefits to the dentist. We will give you an **estimate** of your out-of-pocket expenses, but **this is only an estimate**. Your insurance company will determine your final benefits. You are responsible for any charges your plan does not cover.

In the event your benefit company fails to pay your claim within 90 days, the remaining unpaid balance will automatically become your responsibility and be due in full.

We have financing available. We are happy to discuss your options with you.

APPOINTMENTS AND CANCELLATIONS

When we schedule your appointment, we are reserving a room for your particular needs. We ask that if you need to change an appointment, please give us at least 48 hours notice.

Appointments canceled less than 48 hours in advance, as well as not showing up for a scheduled appointment, are considered broken appointments. Repeated cancellations and/or missed appointments (more than two) will result in an office visit charge and loss of future appointment privileges. We understand emergencies arise, but please be courteous and notify us.

We feel our patients' time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except during emergency treatment for another patient, you can expect us to be prompt.

I have thoroughly read and understand the above conditions of payment and treatment and agree to these conditions.

Patient Signature _____ Date _____

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Welcome to Pingree Smile Center – Tell Us About Yourself

Name: _____
Last First MI Title

Preferred _____ ❑ Male ❑ Female

Address: _____ City _____ State _____ ZIP _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office? _____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____(Please circle preference)

■ Insurance – Primary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Employer: _____

Subscriber Insurance Company Name:

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Employer: _____

Subscriber Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Pingree Smile Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

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Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

Please list each one: _____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: _____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline

Yes	No	If Female, Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of Weeks _____
❑	❑	Are you nursing?

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

When was your last dental visit? _____

When did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Pingree Smile Center, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Sapphire Tooth Whitening	Veneers/Lumineers	Invisalign
Traditional Orthodontics (Brackets)	Smile Makeover	Bonding
Sealants	Crown and Bridge	Implant Crowns
Partials/Dentures	Night/Sport Guards	