Chart#: 002845
FOR OFFICE USE ONLY

Patient Information

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

Gender(M/F):____ Marital Status:____ _____ Birth Date:_____ Social Security #:_____

Driver's License #:_____ E-Mail Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call:_____

FAX _____ Mobile _____ Other _____

Referral Information

Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

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

Gender(M/F): ____ Marital Status:_____ Birth Date:_____ Social Security #:_____

Driver's License #:_____ E-Mail Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext _____ Best time to call:_____

FAX _____ Mobile_____ Other _____

Employment Information

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

Employer Name: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____
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: _____
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: _____

_____

Other Information

Date of Last Dental Visit: _____

Nature of Last Dental Visit (cleaning, filling, pain etc...): _____

Does Your Medical History Include Any Of The Following: (yes/no)

ANGINA _____

ARTHRITIS _____

ASTHMA _____

BLEEDING DISORDER (hemophilia, or other) _____

BYPASS SURGERY _____

CANCER and/or RADIATION THERAPY _____

DIABETES (or a family history of diabetes) _____

EPILEPSY _____

HEARING DISORDER _____

HEART\Mitral Valve Prolapse _____

HEART PROBLEMS (heart attack,murmur,pacemaker,surgery..) _____

HEPATITIS _____

HIGH BLOOD PRESSURE _____

HIV \ AIDS _____

LOW BLOOD PRESSURE _____

JOINT REPLACEMENT _____

ALLERGIC REACTIONS TO MEDICATIONS (please explain) _____

KIDNEY PROBLEMS (dialysis,failure,transplant,other) _____

LIVER PROBLEMS (cirrhosis,jaundice,other) _____

LUNG PROBLEMS (chronic bronchitis,collapse,pleurisy..) _____

LUPUS (SLE) _____

MALIGNANCY/TUMORS _____

MULTIPLE SCLEROSIS _____

NEUROLOGICAL/EMOTIONAL DISORDER(stroke/depression...) _____

STOMACH/INTESTINAL PROBLEMS (blockages,distress,ulcers) _____

TUBERCULOSIS _____

MAY WE REQUEST YOUR MEDICAL RECORDS IF NECESSARY ? _____

Are you pregnant (answer only if it pertains to your gender) _____

PHYSICIANS NAME AND PHONE # _____

Does your dental history include any of the following:

ARE YOU CURRENTLY HAPPY WITH YOUR TEETH? _____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR SMILE? _____

PAIN OR PROBLEM WITH A TOOTH _____

SORENESS OR BLEEDING OF GUMS _____

SENSITIVITY TO SWEET, HOT, OR COLD _____

HEADACHES OR EAR PAIN YOU ASSOCIATE WITH TEETH OR JAW _____

BAD BREATH/UNPLEASANT TASTE _____

FOOD CATCHES BETWEEN TEETH _____

JAW PAIN/DIFFICULT TO OPEN AND CLOSE/CLICKS/POPS _____

I HAVE HAD ORAL SURGERY/GUM SURGERY/ORTHODONTICS IN PAST. _____

UNFAVORABLE DENTAL EXPERIENCE IN PAST _____

(please expain)_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS (list below) _____

List Drugs You Are Presently Taking _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS(list below) _____

_____ _____

In Case Of Emergency, Notify: _____

Name:_____ _____

Phone #:_____

Relation to Patient:_____

ALL PAYMENTS AT THIS OFFICE ARE DUE IN FULL AT THE TIME OF SERVICE REGARDLESS OF INSURANCE COVERAGE.

AS A COURTESY TO YOU:

-YOUR INSURANCE BENEFITS WILL BE VERIFIED BY THIS OFFICE

-YOUR INSURANCE CLAIMS WILL BE SENT BY THIS OFFICE

-ALL CLAIMS SENT BY THIS OFFICE WILL REQUEST REIMBURSMENTS BE SENT DIRECTLY TO YOU

I UNDERSTAND WHAT I HAVE READ AND HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE

Patient Signature _____

Todays date:_____

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

Recency Dental Care

1332 W Northwest Hwy
Palatine, IL 60067
847.776.8700
www.regencydentalcare.com

I,_____, have received a copy of the Notice of the Privacy Practices of the office of Dr. Tremmel. Appointments will be confirms at your request by text, e-mail or voice mail.

OPTING OUT:

☐ I do not want appointment reminder messages left on my home answering system- I understand that the office may charge me should I fail to keep my appointment.

☐ I do not want appointment reminder messages left on my business answering system; I understand that the office may charge me should I fail to keep my appointment

☐ I do not wish my protected health care information to be released to the following Persons:

_____

_____

Please print your name:_____

Please sign and date:

_____ _____

Patient's signature Date:

☐ I decline to sign the Acknowledgement.

OFFICE USE:

The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons: