To help us meet all your dental healthcare needs, please fill out this form. Once filled out, click the "Send Form" button at the end of this form to send it to our office over the internet. We also recommend printing a copy of this form before clicking "Send Form" and bringing it with you just in case there was a problem while transmitting this form.

If you have any questions or concerns, please call us at (630)833-0122 or feel free to e-mail us at Office@ElmhurstDDS.com.

Joseph M Malecki, DDS

538 W. North Ave
Elmhurst, IL 60126

E-Mail: Office@ElmhurstDDS.com
Phone: (630)833-0122
Fax: (630)833-9299

PATIENT INFORMATION

Name: _____ E-mail: _____

Spouse's Name: _____ Parent Or Guardian's Name: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Driver's License #: _____ Birth Date: _____

Gender: ◯ Male ◯ Female

Marital Status: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Employment Status: ◯ Student ◯ Employed ◯ Self Employed ◯ Active Military ◯ Not Employed / Retired

If you are a student, please select what your student status is: ◯ Full Time ◯ Part Time ◯ Not Applicable

If you are employed, please provide your employer's info...

Employer Name: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

What Is Your Current Occupation: _____

If you are student, please provide your school's info...

School Name: _____ Phone: _____

School Address: _____ City: _____ State: _____ Zip Code: _____

In case of emergency, please provide us with emergency contact info...

Name Of Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (*if different from above*)

Name: _____ E-mail: _____

Relationship To Patient: _____ Is this person currently a patient of ours? ◯ Yes ◯ No

Home Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Driver's License #: _____ Birth Date: _____

If the person is employed, please provide the person's employer's info...

Employer Name: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

What Is Their Current Occupation: _____

PRIMARY DENTAL INSURANCE INFORMATION (*if applicable*)

Name Of Insured: _____ Relationship To Patient: _____

Social Security #: _____ Birth Date: _____ Employment Date: _____

Employer Name: _____ Phone: _____ Union Or Local #: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone: _____

Ins. Company Address: _____ City: _____ State: _____ Zip Code: _____

Policy / ID #: _____ Group #: _____ Group Name: _____

How Much Is Your Deductible: _____ How Much Have You Used: _____ Maximum Annual Benefit: _____

SECONDARY DENTAL INSURANCE INFORMATION (*if applicable*)

Name Of Insured: _____ Relationship To Patient: _____

Social Security #: _____ Birth Date: _____ Employment Date: _____

Employer Name: _____ Phone: _____ Union Or Local #: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone: _____

Ins. Company Address: _____ City: _____ State: _____ Zip Code: _____

Policy / ID #: _____ Group #: _____ Group Name: _____

How Much Is Your Deductible: _____ How Much Have You Used: _____ Maximum Annual Benefit: _____

PRIMARY MEDICAL INSURANCE INFORMATION (*if applicable*)

Name Of Insured: _____ Relationship To Patient: _____

Social Security #: _____ Birth Date: _____ Employment Date: _____

Employer Name: _____ Phone: _____ Union Or Local #: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone: _____

Ins. Company Address: _____ City: _____ State: _____ Zip Code: _____

Policy / ID #: _____ Group #: _____ Group Name: _____

How Much Is Your Deductible: _____ How Much Have You Used: _____ Maximum Annual Benefit: _____

PATIENT DENTAL HISTORY (*please provide as much information as you can*)

Name Of Previous Dentist: _____ Office Location: _____

Office Phone: _____ Date Of Your Last Exam: _____

Number Of Years You Went There: _____

What was the reason or reasons you left their practice?

PATIENT DENTAL HISTORY (*continued from previous page*)

Do you like your smile? ○ Yes ○ No

Do you feel pain in any of your teeth? ○ Yes ○ No

Do you have frequent headaches? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

Do you bite your lips or cheeks frequently? ○ Yes ○ No

Do your gums bleed while brushing or flossing? ○ Yes ○ No

Have you had any head, neck or jaw injuries? ○ Yes ○ No

Have you had any orthodontic treatment? ○ Yes ○ No

Have you ever experienced clicking in your jaw? ○ Yes ○ No

Have you ever experienced difficulty chewing? ○ Yes ○ No

Have you ever experienced difficulty in opening or closing your jaw? ○ Yes ○ No

Do you wear dentures or partials? ○ Yes ○ No

If yes, what was the date of placement? _____

Have you ever experienced pain in your jaw, ear or side of your face? ○ Yes ○ No

Are your teeth sensitive to hot or cold liquids or foods? ○ Yes ○ No

Are your teeth sensitive to sweet or sour liquids or foods? ○ Yes ○ No

Have you ever had any difficult extractions in the past? ○ Yes ○ No

Have you ever had any prolonged bleeding following extractions? ○ Yes ○ No

Do you have any sores or lumps in or near your mouth? ○ Yes ○ No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ○ Yes ○ No

Is there anything else not mentioned above that you think may be helpful for the doctor to know?

PATIENT MEDICAL HISTORY

Personal Physician: _____ Office Phone: _____ Date Of Last Exam: _____

Are you in good health? ○ Yes ○ No

Are you under any medical treatment now? ○ Yes ○ No

Do you have a persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks? ○ Yes ○ No

Are you currently taking an aspirin a day or any other blood thinners? ○ Yes ○ No
If yes, what blood thinner(s) are you taking?

Have you been hospitalized for any surgical operation or serious illness in the last 5 years? ○ Yes ○ No
If yes, please explain...

Are you taking any medications including nonprescription medicine? ○ Yes ○ No
If yes, what medications are you taking?

Are you allergic to or have you had any reactions to any of the following?

Local anesthetics (such as Novocain) ○ Yes ○ No

Penicillin ○ Yes ○ No

Sulfa drugs ○ Yes ○ No

Sulfites ○ Yes ○ No

Other antibiotics ○ Yes ○ No

Barbiturates ○ Yes ○ No

Sedatives ○ Yes ○ No

Aspirin ○ Yes ○ No

Iodine ○ Yes ○ No

Any metals (such as nickel, mercury, etc.) ○ Yes ○ No

Codeine ○ Yes ○ No

Vicodin or hydrocodone ○ Yes ○ No

Other narcotics ○ Yes ○ No

Latex ○ Yes ○ No

PATIENT MEDICAL HISTORY (*continued from previous page*)

Please list any other allergies that were not previously listed...

Have you had or do you currently have, use or experience any of the following?

Pregnant or think you may be pregnant	Yes	No	Swollen ankles	Yes	No
Are you nursing	Yes	No	Rheumatic fever	Yes	No
Are you taking oral contraceptives	Yes	No	Angina	Yes	No
Do you wear contact lenses	Yes	No	Anemia	Yes	No
Do you drink alcohol	Yes	No	Cancer	Yes	No
Do you use tobacco of any type	Yes	No	Arthritis	Yes	No
Do you use any controlled substances	Yes	No	Joint replacements or any implants	Yes	No
Do you use any street drugs	Yes	No	Hepatitis or jaundice	Yes	No
Hay fever or allergies	Yes	No	Sexual transmitted diseases	Yes	No
Recent weight loss	Yes	No	Stomach or digestive problems including ulcers	Yes	No
Fen-Phen or Redux	Yes	No	Diverticulitis or gastrointestinal problems	Yes	No
High blood pressure	Yes	No	AIDS, HIV or related diseases or infections	Yes	No
Low blood pressure	Yes	No	Thyroid problems	Yes	No
Heart disease	Yes	No	Tuberculosis	Yes	No
Heart attack	Yes	No	Radiation therapy	Yes	No
Cardiac pacemaker	Yes	No	Glaucoma or eye problems	Yes	No
Mitral valve prolapse	Yes	No	Epilepsy or convulsions	Yes	No
Respiratory problems	Yes	No	Leukemia	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Lung disease	Yes	No	Kidney or bladder diseases or problems	Yes	No
Heart trouble	Yes	No	Liver disease	Yes	No
Heart murmur	Yes	No	Skeletal diseases or problems	Yes	No
Chest pains	Yes	No	Muscular diseases or problems	Yes	No
Frequently tired or easily winded	Yes	No	Neurological diseases or problems	Yes	No
Asthma	Yes	No	Psychological diseases or problems	Yes	No
Stroke	Yes	No	Depression or anxiety	Yes	No
Fainting or seizures	Yes	No			

Please list any other diseases, problems or pain that you have or are experiencing that were not listed or provide details for any of the above...

NOTICE OF PRIVACY PRACTICES

Listed below is this practice's Notice Of Privacy Practices. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted, required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice Of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice Of Privacy Practices and to make new provisions effective for all health information that it maintains. I understand that I can obtain this practice's current Notice Of Privacy Practices on request.

OFFICE FINANCIAL POLICY

Listed below is this practice's Financial Policy. The Policy is as follows:

- As a courtesy to you, the patient, this office will bill your insurance company on your behalf. Please note that most insurance companies do not cover the entire amount of the charges billed to them. You should be prepared to pay any difference. Once the insurance company pays on your claim, you have 90 days to pay off the remainder of the balance. If there is no payment made to our office within the 90 grace period, we will forward your account to our collection agency. If you have made payments within the 90 day grace period, but do not have the balance paid off in full, your account will receive a $15.00 per month late fee charge.

- If you do not have insurance coverage or you are using a discount insurance plan, payment is due in full at the time services are rendered with no exceptions.

- We no longer offer an in office payment plan. You can pay for the work as it is completed or apply for Care Credit, which is a credit card designed for dental and medical procedures. We will not start a new procedure until the previous one is paid off in full.

- In the event that your insurance carrier does not pay on a claim, the debt becomes your sole responsibility and it is then up to you to collect the amount from your insurance carrier.

- Any unpaid insurance claims become your responsibility after 30 days.

- Appointments must be cancelled at least 24 hours in advance before the scheduled appointment to avoid a $25.00 cancellation fee.

- There will be a $50.00 failed appointment fee if you fail to call and fail to show for the appointment. The office does call at least 48 hours before your appointment as a courtesy. There are no exceptions allowed due to the fact we have patients on waiting lists for appointments and without a 24 hour notice we will not have enough time to fill the schedule.

- If you walk in without an appointment, you should know that the doctor might not be able to see you and if he is able to, you will more than likely have to wait for a room to become available. Remember that other patients have scheduled appointments so they come first. If it is an emergency, please call first and we will try to give you the best time available to come in.

And remember, the staff is here to be of service to you, the patient, so feel free to ask any questions or discuss any problems with us.
We look forward to serving you.

PATIENT HEALTH INFORMATION - AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient (parent / guardian if minor)
(**Please either type or sign your full name here**)

_____

Date

_____

Relationship to patient (if signed by a representative of the patient)

NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received this practice's Notice Of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

X _____

Signature of patient (parent / guardian if minor)
(**Please either type or sign your full name here**)

_____

Date

OFFICE FINANCIAL POLICY - PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received this practice's Financial Policy written in plain language.

X _____

Signature of patient (parent / guardian if minor)
(**Please either type or sign your full name here**)

_____

Date

Print Form **Send Form**