Joseph A LaSpisa DDS
Practice Limited to Oral & Maxillofacial Surgery

4949 EUCLID AVE.
SUITE A
PALATINE, IL 60067
847/397-1111
Fax 847/397-1142

***THANK YOU*** *for coming to our office for your dental care. In order for us to properly evaluate your dental and medical health, we request you to fill out **all** parts of this history form. Before any treatment or diagnostic procedures begin, we will inform you of our standard office practices and give you an opportunity to ask questions.*

## GENERAL INFORMATION

| | | | |
|---|---|---|---|
| DR. MISS PATIENT NAME FIRST MIDDLE LAST<br>MR. MS.<br>MRS. | | BIRTH DATE | SOCIAL SECURITY # |
| DR. MISS NAME OF RESPONSIBLE PARTY - IF DIFFERENT FROM ABOVE<br>MR. MS. | DRIVERS LICENSE # | STATE | SOCIAL SECURITY # |
| RESIDENCE ADDRESS NUMBER STREET | | | DATE OF BIRTH |
| CITY STATE ZIP | | EMAIL | |
| WORK PHONE HOME PHONE CELL PHONE | | FULL TIME STUDENT YES ☐ NO ☐<br>WHERE | |
| OCCUPATION OF RESPONSIBLE PARTY | EMPLOYER | | |
| BUSINESS ADDRESS NUMBER STREET | | | |
| CITY STATE ZIP | | | |
| IN CASE OF EMERGENCY, PERSON TO NOTIFY (Not Living With You) | | RELATIONSHIP | |
| WORK PHONE HOME PHONE CELL PHONE | | | |
| HOW WERE YOU REFERRED TO US? | | | |

_____I have been offered a copy of Meadows Dental Care (MDC) Notice of Privacy Practices. I understand that MDC has the right to change its Notice of Privacy Practices from time to time and that I may contact MDC at any time to obtain a current copy of the Notices of Privacy Practices.

_____I authorize the release of my dental health information to my dental insurance companies. I hereby authorize payment directly to Meadows Dental Group, Ltd. of the group insurance benefits otherwise payable to me.

_____I understand and agree that I will be responsible to pay for missed appointment or insufficient cancellation notice fees of $50.00 per instance, and/or late charge fees of 1½ % per month/18 % per annum

_____I understand and agree in the event that this account goes past due and we are forced to use an outside collection agency or law firm, up to 30 % of the balance will be added as collection/ attorney's fees.

_____I understand and agree that if we are forced to file a lawsuit to collect the outstanding balance, you will be liable for all court costs whether judgment has been entered or not.

Signature_____Date_____

## BENEFIT SECTION

| | | | | |
|---|---|---|---|---|
| NAME OF INSURANCE COMPANY | | | GROUP NUMBER | |
| ADDRESS OF INSURANCE COMPANY NUMBER STREET | | | INS ID# | |
| CITY STATE ZIP | | | | |
| EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST | | DATE OF BIRTH | EMPLOYEE/SUBSCRIBER SOC. SEC.# | |
| EMPLOYEE SUBSCRIBER MAILING ADDRESS | CITY | STATE | ZIP | |
| EMPLOYER (COMPANY) NAME AND ADDRESS | | | | |
| IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | GROUP NO. | INS ID # | |
| EMPLOYEE/SUBSCRIBER FIRST MIDDLE LAST | | EMPLOYEE/SUBSCRIBER SOC. SEC.# | RELATIONSHIP TO EMPLOYEE<br>SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ | |
| EMPLOYER (COMPANY) NAME AND ADDRESS | | | DATE OF BIRTH | |

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# Medicare Private Contract Affidavit

Joseph LaSpisa D.D.S. is excluded from participation under the Medicare program; in addition, Patient and Dentist agree that Patient is not now facing an emergency or urgent health care situation.
By signing this contract, Patient does the following:

- Agrees not to submit a Medicare claim (or to request that Dentist submit a claim) for services or items supplied by Dentist, even if they are otherwise covered under Medicare;
- Agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Dentist, and understands that no reimbursement will be provided under Medicare for those services or items;
- Acknowledges that Medicare limits do not apply to amounts that Dentist may charge for such services or items;
- Acknowledges that Medicare plans do not, and other supplemental insurance plans may elect not to, make payments for item and services covered by this contract, because payment is not made under Medicare;
- Acknowledges that Patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Medicare. (Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other dentists who have not opted out.)

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Dentist's current opt-out period.

SIGNATURE DATE

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# DENTAL HISTORY

Purpose of this appointment:

[ ] Consultation for Wisdom Teeth [ ] Consultation for Dental Implants

[ ] Broken Tooth [ ] Pain

[]OTHER

_____

Date of last Dental Exam: _____

| | | |
|---|---|---|
| Have you ever injured your face, mouth, or teeth? | [ ] YES | [ ] NO |
| Do you habitually breathe through your mouth? | [ ] YES | [ ] NO |
| Do you snore? | [ ] YES | [ ] NO |
| Do you have allergies which cause you to have a stuffed nose? | [ ] YES | [ ] NO |
| Do you clench or grind your teeth? | [ ] YES | [ ] NO |
| Are your jaws ever sore or tired? | [ ] YES | [ ] NO |

Do you have any other dental issues, questions, or concerns?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

# DENTAL INFORMATION

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## MEDICAL HISTORY

**1.)** CARDIOVASCULAR SYSTEM: Do you have any cardiovascular/heart problems? [ ] NO **[ ]YES** _____

**2.)** ENDOCRINE: Do you have any endocrine (glandular) disorders? [ ] NO **[ ]YES** _____

**3.)** GASTROINTESTINAL Do you have any gastrointestinal/stomach problems? [ ] NO **[ ]YES** _____

**4.)** GENITOURINARY TRACT: Do you have any kidney or bladder problems? [ ] NO **[ ]YES** _____

**5.)** HEMATOLOGIC Do you have any hematologic/bleeding disorders? [ ] NO **[ ]YES** _____

**6.)** INFECTIOUS DISEASES: Do you have any infectious diseases? [ ] NO **[ ]YES** _____

**7.)** NEUROLOGICAL : Do you have any neurological problems? [ ] NO **[ ]YES** _____

**8.)** RESPIRATORY SYSTEM: Do you have any lung or breathing problems? [ ] NO **[ ]YES** _____

**9.)** Do you now or have you ever had any of the following conditions? [ ] NO **[ ] IF YES, PLEASE CHECK BELOW**

**[ ]** Allergies to Medications:
LIST_____
_____
**[ ]** Allergies to Latex
**[ ]** Arthritis
**[ ]** Cancer
**[ ]** Diabetes

**[ ]** Ear/hearing disorders:
(describe):_____
**[ ]** Eye/visual disorders:
(describe):_____
**[ ]** Headaches
How many per week?_____
**[ ]** High Blood Pressure/Hypertension
**[ ]** Joint replacement

**[ ]** Liver problems
**[ ]** Multiple Sclerosis
**[ ]** Muscular Dystrophy
**[ ]** Osteoporosis
**[ ]** Rheumatic Fever
**[ ]** Scarlet Fever
**[ ]** Systemic Lupus Erythematosi

**10.)** **SOCIAL:**
Do you drink more than 2 alcoholic beverages per day? [ ] NO **[ ]YES** _____
Do you smoke tobacco? [ ] NO **[ ] YES** _____# packs/day Do you chew tobacco products? [ ] NO **[ ]YES**

**11.)** **WOMEN:**
Are you pregnant? **[ ] YES** Date Due: _____ [ ] NO
Are you nursing? **[ ] YES** [ ] NO Are you taking Birth Control Pills? **[ ] YES** [ ] NO

**12.)** **OTHER: Do you have any other medical conditions not covered in this questionnaire?** **[ ] YES** [ ] NO
**PLEASE LIST IF YES**

_____

**13.) Are you taking any medications including over the counter drugs? YES [ ] NO[ ] PLEASE LIST IF YES**

_____

**14.) Name and phone number of primary care physician**

_____

I verify that the information I have given is true and accurate to the best of my knowledge. I will not hold Meadows Dental Group, Ltd. its employees, staff, or my dentist responsible for any errors or omissions I may have made in the completion of this form. I authorize my dentist to release, request, and discuss my medical conditions with my physicians. After discussion with me, I authorize my dentist and any of his staff which he deems fit to take x-rays, study models, photographs or any other procedures necessary to make a complete and thorough diagnosis of my dental conditions. In case of emergency situations, I also authorize my dentist and any of his staff, which he seems fit, to perform any forms of treatment and render any medications which may be medically necessary or indicated.

_____ _____ _____
*Signature of patient or legal guardian* *Please Print Your Name & Relationship* *Date*

**FOR OFFICE USE ONLY**

Medical & Dental History reviewed by:
Signature of dentist: _____Date: _____