14430 John Humphrey Drive
Orland Park, IL 60462

Chart # _____
FOR OFFICE USE ONLY

Patient Information

Please take a moment to enter or update your information to help up ensure the quality of your care is excellent

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

Title: _____ Gender: ◯ Male ◯ Femaile Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS # _____ Prev.Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

How may we contact you for your appointment reminders? ☐ Text Msg ☐ Email

Who may we contact in case of an emergency?_____ Tel#: _____

We'd love to know how you heard about us! Name of person, office, or other source referring you to our practice:

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in advance at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for services at the time of treatment with either Cash, Check, American Express, Visa, Mastercard, Discover or Care credit. I further agree that the charges for services shall be as billed unles objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss the statement or my treatment.

- ☐ I have read the above conditions of treatment and payment and agree to their content.
- ☐ I authorize and consent to any x-rays, flouride, examination, anesthetic, sedative or dental treatment rendered under the general, direct or indirect supervision of Rita A. Kapmarski, DDS and her Associates, staff and agents as she deems necessary. This authorization will remain in effect until cancelled in writing by me.
- ☐ Our office is compliant with HIPPA Regulation. We will not use or disclose your health information without your written consent. By checking this box you understand and agree to our privacy policy and you are aware that we are compliant with Federal Regulations regarding your privacy.
- ☐ I am aware that any cancellation or changes with my appointment MUST be made 24 hours prior to my reserved time. Failure to do so will result in a charge of $50 for a Hygiene routine cleaning appointment and $100 for a Provider treatment appointment.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Response Date: _____

Please Answer the Following:

Yes No Are you being treated by a physician now?
If yes, for what?

Yes No Have you been hospitalized within the last 3 years?
If yes, why?

Yes No Have you been taking bisphosphonates?

Have you experienced:

Yes No Chest pain?
Yes No Swollen ankles?
Yes No Shortness of breath?
Yes No Recent weight loss or fever?
Yes No Persistant or blood when coughing?
Yes No Bleeding problems, bruise easily?
Yes No Difficult swallowing?
Yes No Diarrhea, constipation?
Yes No Frequent vomiting or Nausea?
Yes No Ringing in ears?
Yes No Headaches?
Yes No Blurred Vision?
Yes No Seizures?
Yes No Excessive thirst?
Yes No Frequent urination?
Yes No Difficulty urinating, blood in urine?
Yes No Dry mouth?
Yes No Joint pain?

Do you have or have you had:

Yes No Eye/Skin disease?
Yes No STD's, AIDS, Herpes, HPV?
Yes No Psychiatric care?
Yes No Prosthetic heart valve?
Yes No Blood transfusions?
Yes No Surgeries?

Are you taking:

Yes No Any Prescriptions?
Yes No OTC (Over The Counter) drugs?
Yes No Tobacco/any form?
Yes No Recreational drugs?

Women only:

Yes No Are you or could you be pregnant?
Yes No Are you taking birth control?

Please check anything that applies:

- ☐ Alcohol/Drug Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Celocin
- ☐ Chemical Depend
- ☐ Chemotherapy
- ☐ Codeine Allergy
- ☐ Coumidin
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Erythomycine Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart ByPass Surgery
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitus
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Respiratory Problems
- ☐ PREMED Antibiotics
- ☐ PREMED Vallium
- ☐ Sinus Problems
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Sulfa Allergy
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Tumors
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Other
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Any other diseases or medical problems NOT listed above? _____

_____

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