**Raffi Leblebijian, DDS, FICOI**
**Syreeta Jones, DDS**
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# Dr. Raffi
GENERAL & IMPLANT DENTISTRY

876 N Convent Street, Bourbonnais, IL 60914
1-833-DR-60914 dr60914.com

## PATIENT INFORMATION
## CONFIDENTIAL

**Welcome!**

Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

## BEST WAY TO CONTACT

Home: _____ Work: _____

E-mail: _____ Cell: _____

When is the best time to reach you? _____

In the event of an emergency, who should we contact? _____

Name: _____

Relationship: _____

Work #: _____ Home #: _____

Whom may we thank for referring you? _____

## BIRTHDATE: _____

(Check appropriate selection)

❑ Male ❑ Female
❑ Minor ❑ Single
❑ Married ❑ Divorced
❑ Widowed ❑ Seperated

## RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Address: _____
Street City State Zip

Home phone _____ Employer: _____ Work phone: _____

Is this patient currently a patient in our office? ❑ Yes ❑ No

## INSURANCE INFORMATION

Name of Insured: _____ Relationship _____

Birthdate: _____ Soc. Sec. # **and** Acct. ID#: _____

Employer: _____ Work phone: _____

Address of employer: _____
Street City State Zip

Insurance company: _____ Group#: _____

Ins. Co. address: _____ How much is your deductible? _____

## Do You Have Any Secondary Insurance?

❑ **Yes** ❑ **No** **If yes, complete the following**

Name of insured: _____ Relationship: _____ Birthdate: _____

Soc. Sec.# or Acct. ID#: _____ Employer: _____

Group#: _____ Insurance Company: _____

**As a courtesy to our patients, if you are 10 minutes late for your appointment we may have to reschedule, but we will try our best to accommodate you.**

**A 48 hr. notice is required;** otherwise there is a missed appointment fee of $25.00 - $100.00 charged to your account.

# MEDICAL HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | |
|---|---|---|
| Are you under a physician's care now? | ❑ Yes ❑ No | Physician's name: _____<br>Physician's phone: _____ |
| Are you wheel chair dependent? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Are there any disabilities (physical or mental) that the office should be aware of? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Are you on a special diet? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Do you use tobacco? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Do you use controlled substances? | ❑ Yes ❑ No | If yes, please explain: _____ |
| Do you use a C-Pap machine for Sleep Apnea? | ❑ Yes ❑ No | If yes, please explain: _____ |

**Women: Are you**

Pregnant? ❑ Yes ❑ No  Trying to get pregnant? ❑ Yes ❑ No  Nursing? ❑ Yes ❑ No  Taking oral contraceptives? ❑ Yes ❑ No

**Are you allergic to any of the following?**

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa

❑ Other If yes, please explain: _____

**Do you have, or have you had, any of the following?**

- ❑ ADHD/ADD
- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Autism
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Down Syndrome
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Thirst
- ❑ Excessive Bleeding
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hearing Impaired
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

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# PATIENT DENTAL HISTORY

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ❑ | ❑ |
| 2. Are your teeth sensitive to hot or cold liquids/food? | ❑ | ❑ |
| 3. Are your teeth sensitive to sweet or sour liquids/food? | ❑ | ❑ |
| 4. Do you have pain in any of your teeth? | ❑ | ❑ |
| 5. Do you have any sores or lumps in or near your mouth? | ❑ | ❑ |
| 6. Have you had any orthodontic work? | ❑ | ❑ |
| 7. Have you ever experienced any of the following problems in your jaw? | ❑ | ❑ |
| a) Clicking? | ❑ | ❑ |
| b) Pain (joint, ear, side of face)? | ❑ | ❑ |
| c) Difficulty in opening or closing? | ❑ | ❑ |
| d) Difficulty in chewing? | ❑ | ❑ |
| 8. Do you clench or grind your teeth? | ❑ | ❑ |
| 9. Do you bite your lips or cheeks frequently? | ❑ | ❑ |
| 10. Have you ever had any difficult extractions in the past? | ❑ | ❑ |

What is the reason for your visit today? _____

_____

Date of last dental visit: _____

What was done at your last dental visit? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN**_____ DATE _____

Welcome to all new and established patients. We wish to thank you for choosing us as your dental care provider. Our objective is to provide you with the highest quality dental care in the most cost-effective manner. However, the ability to achieve this objective depends greatly on your understanding of our financial policy. If you have dental insurance we will file insurance claim forms on your behalf. **We do this as a courtesy to our patients**. Even though we will file insurance claims for you, we need your active participation in the insurance claims process.

**COMMERCIAL INSURANCE PATIENTS:**

Insurance coverage is not a guarantee of payment. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Insurance companies frequently set fees below our customary charges. You are still obligated to pay the full amount (meaning that you are responsible for paying the amount that your insurance may say is "above their customary fees) unless we have negotiated a discounted fee schedule with that particular insurance company.

**PPO PLAN:** If we are participating providers in you PPO, we will submit a claim for you. **If you have not met your deductible or have a co-pay, this is due at the time of service.** You are required to pay your co-payment at each office visit.

**PATIENTS WITH NO INSURANCE:**

Please understand that you are responsible for the balance due on your account as a result of any and all professional services rendered by this office, regardless of you insurance status. Payments may be made to this office with cash or personal checks.

- **A $25.00 fee will be assessed on all returned checks.**
- **A $25.00 fee will be assessed for any bills sent to your home 30 days past due.**

(continued on back)

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## FINANCES

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. If you have any questions concerning financial arrangement it will be our pleasure to assist you. We do accept Cash, Checks, Major Credit Cards, Debit Cards, and Care Credit.

*In the case of children of divorced parents, the custodial parent will be financially responsible for providing this office with repayment, regardless of divorce settlement.*

X _____ _____

***Signature of patient or parent if minor*** *date*

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## Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____ _____

***Signature of patient or parent if minor*** *date*

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## HIPAA

I have read and understand the HIPAA information posted on the wall in the waiting room of Dr. Raffi Leblebijian.

X _____ _____

***Signature of patient or parent if minor*** *date*

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