Prairie Dental, Ltd.

23909 W. Renwick Rd.
Plainfield, IL 60586

Patient Information

Date_____

Email_____

Patient_____

Address_____

_____

City_____ State_____ Zip_____

CONTACT INFORMATION

Home #_____

Work#_____

Cell#_____

Sex: ☐ M ☐ F Age:_____ Birthdate_____

_____

☐ Single ☐ Married ☐ Divorced ☐ Seperated

Patient SS#

_____

Occupation_____

Spouse's SS#_____

Occupation_____

Employer_____

Whom may we thank for referring you?

_____

EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name_____

Phone Number: _____

Dental Insurance

Subscriber's Name

_____

Birth date _____SS#_____

Relation to Patient_____

Insurance Co.

_____

Group#

_____

Employer_____

Address_____

Is patient covered by addition insurance?

☐ Yes ☐ No

Subscriber's Name

_____

Birth date_____ SS#_____

Insurance Co.

_____

Group#

_____

Employer_____

Address_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with- _____ and assign directly to Dr. P. Lukawski, D.D.S all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____

Relationship _____ **Date** _____

ALLERGIES

☐ No Know allergies	☐ Anesthetic	☐ Sulfa
☐ Aspirin	☐ Ibuprofen	☐ Household Bleach
☐ Codeine	☐ Clindamycin	☐ Iodine
☐ Latex	☐ Erythromycin	☐ Mouth Rinse
☐ Penicillin	☐ Tetracycline	☐ Other

MEDICATIONS

List all medications, Vitamins, herbs, supplements, and over-the-counter medications you are currently taking:

_____

_____

Do you PRE MEDICATE before a dental procedure? If Yes,Why?_____

PHYSICANS NAME_____

Are you taking any blood thinners? (Asprin, Ibuprofen, Coumadin, Plavix)_____

Are you taking any bisphosphonates? (Actonel, Boniva, Fosamax, Zometa, Aredia)_____

DENTAL HISTORY

Place a mark "Yes" or "No": to indicate if you have had any of the following:

Dry mouth	☐ Yes ☐ No	History of periodontal disease	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Sensitive teeth	☐ Yes ☐ No
Gums swollen or bleeding	☐ Yes ☐ No	Sores or growth in your mouth	☐ Yes ☐ No
Loose teeth or broken fillings	☐ Yes ☐ No	Cigarette, pipe or cigar smoking	☐ Yes ☐ No
Mouth Breathing	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No

Date Last Dental Exam: **PREVIOUS DENTIST** **Date Last Xrays:**

Place a mark "Yes" or "No": to indicate if you have had any of the following:

Artificial Heart Valves
☐ Yes ☐ No **Date**_____
Artificial joints..... ☐ **Yes** ☐ **No**
Congenital Heart Lesion
☐ Yes ☐ No
Heart Murmur..... ☐ Yes ☐ No
Heart Problems..... ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Low/ Blood Pressure ☐ Yes ☐ No
Mitral Valve Prolapse
☐ Yes ☐ No
Pacemaker..... ☐ Yes ☐ No
Date Placed_____
Shortness of Breath ☐ Yes ☐ No
Stroke..... ☐ Yes ☐ No
Stent..... ☐ Yes ☐ No
Date Placed_____
AIDS..... ☐ Yes ☐ No
Anemia..... ☐ Yes ☐ No
Arthritis..... ☐ Yes ☐ No
Asthma..... ☐ Yes ☐ No
Back Problems..... ☐ Yes ☐ No
Hemophillia..... ☐ Yes ☐ No

Blood Disease..... ☐ Yes ☐ No
Blood Transfusion..... ☐ Yes ☐ No
Cancer..... ☐ Yes ☐ No
Cerebral Palsy ..... ☐ Yes ☐ No
Chemotherapy..... ☐ Yes ☐ No
Circulatory problems... ☐ Yes ☐ No
Cortisone Treatments.... ☐ Yes ☐ No
Cough, persistent..... ☐ Yes ☐ No
Diabetes..... ☐ Yes ☐ No
Blood sugar level_____
Drug use..... ☐ Yes ☐ No
Emphysema..... ☐ Yes ☐ No
Epilepsy..... ☐ Yes ☐ No
Fainting or dizziness..... ☐ Yes ☐ No
Glaucoma..... ☐ Yes ☐ No
Headaches..... ☐ Yes ☐ No
Hepatitis....Type_____ ☐ Yes ☐ No
Herpes..... ☐ Yes ☐ No
HIV Positive..... ☐ Yes ☐ No
Jaundice..... ☐ Yes ☐ No
Please List any conditions or illness not mentioned._____
_____

Nervous Problems..... ☐ Yes ☐ No
Psychiatric Care..... ☐ Yes ☐ No
Radiation Treatment..... ☐ Yes ☐ No
Respiratory Disease..... ☐ Yes ☐ No
Scarlet Fever..... ☐ Yes ☐ No
Sinus Trouble..... ☐ Yes ☐ No
Skin Rash..... ☐ Yes ☐ No
Special Diet..... ☐ Yes ☐ No
Swollen Neck Glands..... ☐ Yes ☐ No
Thyroid Problems..... ☐ Yes ☐ No
Tonsillitis..... ☐ Yes ☐ No
Tuberculosis..... ☐ Yes ☐ No
Tumor of Head/Neck..... ☐ Yes ☐ No
Ulcer..... ☐ Yes ☐ No
Venereal Disease..... ☐ Yes ☐ No
Weight loss, unexplained ☐ Yes ☐ No

WOMEN

Are you Pregnant?..... ☐ Yes ☐ No
Due Date_____
Is there a possibility of pregnancy?
☐ Yes ☐ No : Nursing ☐ Yes ☐ No

Prairie Dental
Paul Lukawski D.D.S.

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

General: Understand that (regardless of any insurance status) you are responsible for the balance due on you account. You are responsible for any and all professional services rendered. This includes but not limited to: dental fees, surgical procedures, tests, office procedures, medications, and also any other services not directly provided by the dentist.

Missed appointments: Unless we receive notice of cancellation **48 hours** in advance, **you will be charged $45.00**. Please help us serve you better by keeping scheduled appointments.

Insurance: Please remember your insurance policy is a contract between **you and your insurance company**. We are not a party to that contract.

As a courtesy to you, our office provides certain services including a pre-treatment estimate, which we send to the insurance company at your request. **It is physically impossible for us to have knowledge and keep track of every aspect of your insurance**. It is up to you to follow up with your insurance company as to the benefits they will provide.

If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

_____- I Have No Dental Insurance

_____- I Have Dental Insurance
-I will provide your office with an insurance form and assign my insurance carrier to pay you.

Unpaid patient balances over 30 days old will be subject to monthly interest 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for collection, attorney, and all court costs associate with the recovery of monies due on the account. I have read and understand the financial policy of Dr. Paul Lukawski.

Signature_____**Date**_____