Welcome to our family of fine patients and thank you for selecting us as your personal dental care team. We will strive always to make your relationship with us as pleasant and rewarding as possible.

Responsible, professional dental care relies on providing a firm foundation on which we can base recommendations for your dental health. Therefore, your first visit with us will consist of a thorough examination and any necessary x-rays that will aid us in giving you the finest dental care possible. Feel assured that we will only recommend the minimal x-rays needed and that we take every precaution possible to provide a safe environment.
Dental health is not a one-time affair and a plan of preventive dentistry is the most important service we have to offer you. Preventive examinations, or annual dental physicals as we call them, are scheduled on a regular basis to give you the maximum opportunity for long term dental health. Keeping your own natural teeth throughout your lifetime is possible if you desire it, and we will show you how to control your dental destiny.

Enclosed you will find your health record registration forms that we would like you to complete and bring to our office on the day of your visit. Your overall health can significantly affect your oral health and a thorough health record allows us to make a more thorough diagnosis.

Our goal is for you to be happy with our office and completely satisfied in feeling that we are unconditionally committed to making you feel special. A misunderstanding can be an obstacle to forming this relationship and we ask that if at any time you have a question or are unhappy about any treatment, fee, or service, please discuss it with us promptly and openly.

A long term, mutually satisfying relationship, which gives you the ability to maintain optimum dental health, is what we want for you, your family, and for our own satisfaction. Thank you again for selecting us and we are looking forward to seeing you soon.

Yours in better dental health,

HOMERUN DENTAL

PATIENT REGISTRATION

First Name | Last Name | Preferred Name | Middle Initial

Patient is: Policy Holder Responsible party

Responsible Party (if someone other than the patient)

First Name | Last Name | Preferred Name | Middle Initial

Address | City | State | Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____ Other _____

Male Female Marital Status: Married Single Partner Divorced Separated Widowed

Date of Birth _____ Social Security Number_____ Drivers License Number_____

Email Address_____ Whom may we thank for referring you to our practice? _____

Patient Information

Address | City | State | Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____ Other _____

Male Female Marital Status: Married Single Partner Divorced Separated Widowed

Date Of Birth_____ Social Security Number _____ Drivers License Number_____

Email Address _____ Occupation_____

HOMERUN DENTAL

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured | Insured Social Security Number | Insured Member ID

Relationship To Insured: Self Spouse Child Other

Insured Date of Birth _____

Employer | Address | City/St/Zip

Insurance Company | Address | City/St/Zip

Group/Plan# _____

Secondary Insurance Information

Name of Insured | Insured Social Security Number | Insured Member ID

Relationship To Insured: Self Spouse Child Other

Insured Date of Birth _____

Employer | Address | City/St/Zip

Insurance Company | Address | City/St/Zip

Group/Plan# _____

HOMERUN DENTAL

Patient Name _____ Date of Birth _____

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

Are you under a physicians care now?	Yes	No	If yes, please explain:_____
Have you 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 medication, pills or drugs?	Yes	No	If yes, Please explain:_____
Do you take or have you taken Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use a controlled substance?	Yes	No	

Woman: Are You …

Pregnant/Trying to get pregnant?	Yes	No	Taking Contraceptives?	Yes	No	Nursing?	Yes	No			

Are you allergic to any of the following?	Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex	Local Anesthetics

Other If yes please explain _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	no
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting or Dizziness	Yes	No	Kidney Problems	Yes	No	Intestinal Disease/Stomach	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain In Jaw joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

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

Comments:

_____

_____

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_____

NOTICE OF PRIVACY PRATICE ACKNOWLEGEMENT

I understand, that under the Health Insurance and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment, or health care operations. I also understand you are not required to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

HomeRun Dental
3745 N. Clark St.
Chicago, IL 60613

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below:

Date:	**Initials:**	**Reason:**

HOMERUN DENTAL

Patient Care Cancellation and Financial Agreement

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by *Homerun Dental* and understand that payment is due at the time of service unless prohibited by an existing contract between *Homerun Dental* and the insurance company. For procedures that are billed to my insurance I understand that I become personally responsible for the charges in the event that my insurance company does not provide payment within 60 days and have provided a credit card listed below to cover these charges.

I understand that my insurance company *may not* cover all necessary balances and may send the check to the wrong party. In the event that the insurance company mistakenly sends a reimbursement check to me for services that were rendered but not previously paid for I will endorse the check to *Homerun Dental* within 5 business days of the said payment; I hereby authorize the outstanding balance to be charged to the credit card listed below. If my insurance company reimburses *Homerun Dental* for services that I paid for at the time of service or prepaid, I understand *Homerun Dental* will reimburse the credit card listed below that day the payment is received. In those instances in which an insurance company has made a partial payment for services, I authorize *Homerun Dental* to collect outstanding balances including, co-pays, co-insurance, deductibles, and non-covered services on my credit card listed below.

I understand that *Homerun Dental* requires a 24-hour notice to cancel or reschedule an appointment and failure to provide such notice will result in a $50 non-refundable deposit towards any future appointments.

If I prefer to have appointments that are 2 hours or more I agree to provide a non-refundable deposit of 50% of the services to be provided.

If the following credit card number or payment by check is invalid or does not accept charges, I authorize you to $25 re-billing fee on the credit card listed below.

Name: _____

Credit Card Number: _____
Expiration Date:_____**Security Code (located on the back of the card):** _____

Signature:_____ **Date:**_____
Witness: _____ **Date:** _____

_____**I would prefer to have statements mailed to me before charging my credit card so that I**
Initials **can have the opportunity to pay by check. However I understand that if payment is not received within 30 days of the statement date, that balance will be charged to the credit card listed above, including a $25 late payment charge.**

HOMERUN DENTAL

Dental History

Name:_____ Date:_____

Reason for todays Visit_____

Date of last Exam_____ Date of Last dental X-rays_____

Date of last dental cleaning_____ How often do you floss?_____

How often do you brush?_____ Type of toothbrush (circle one): Regular Electric

Do you use mouthwash or some other type of rinse? Yes No Describe_____

Do you have any dental problems now? Yes No Describe_____
_____

Have you ever had an upsetting dental experience? Yes No Describe_____
_____

Have you ever had: Orthodontics Periodontal Surgery Oral Surgery

Please circle any of the following conditions that apply to you:

Bad Breath	Grinding Teeth	Sensitivity to Hot
Bleeding Gums	Lose Teeth or Broken Filling	Sensitivity to Cold
Clicking or popping jaw	Periodontal Treatment	Sensitivity When Biting
Food collection between Teeth	Sores or Growths in your mouth	Sensitivity to Sweets
Tired jaws in the morning	Sore Facial Muscles	Headaches or Neck Aches
Difficulty in opening or closing mouth	Snoring	Wear a Night Guard

Are you happy with the appearance of your teeth? Yes No If no, please describe_____
_____

Other:_____

_____

Pervious Dentist Name:_____