Ultimate Comprehensive Dentistry
4307 N. Central Ave – Chicago, IL 60634
Phone: 1(773) 286-0300 – Fax: 1(773) 286-0340

INSURANCE BENEFITS & Office Policy ACCOUNT STATEMENTS

As a courtesy to you, we check your Insurance Benefits with your carrier. Although, we call to check benefits we do not guaranty payment for services rendered. Payment for the services rendered to you or your family member is paid directly to our office. An insurance form is not considered payment.
Filing of your insurance form is a service we provide at no charge. Payment arrangements are requested at the time of your visit. All fees for any covered or non-covered services, deductibles and co-insurance as defined by your insurance, are **your responsibility**. We do not contact your carrier for explanation of non-covered services. If your insurance company pays less than their estimated portion and your account reflects a balance, we will send a statement with the respective balance. Balance is **due in full** within a **maximum of 30 days** or otherwise arranged**.**
If you do not carry any insurance, **payment is due in full at the time services are rendered** (unless discussed other wise). Monthly interests (**3%** per month will be included) are applied to accounts that present any balance and/or payments not made the dates discussed with staff.

PAYMENT METHOD

- **CASH**
- **Debit Card** or **Credit Cards**: (Visa, MasterCard, Discover) **NO AMERICAN EXPRESS**
- Personal **CHECK**: quick system check for available funds. If funds are insufficient, check acceptance may be denied (returned check fee: ***$35***)
- **Automatic billing** to your Credit Card (for balance of charges not paid by insurance or on-going treatments) * *Pre-authorized Healthcare form to be filled.*

TREATMENT ESTIMATE

The cost of your treatment will be based on the work that was done and the fees that are normally charged for the various procedures completed. A treatment plan will be provided after your 1st Dental appointment when you come for an Exam and Cleaning. You can then decide accordingly to fit your budget. Fees quoted will be honored for 90 days, beyond the time of the treatment plan. Fees will be adjusted to reflect any cost increase without prior notice.

PLEASE NOTE

We reserve the right to charge **$90** for **broken and cancelled appointments** without a **48 hour** notice for the time reserved. **Please be considerate to staff and to patients that may present certain urgency and kindly contact us when you cannot keep your appointment**. In the case you are more than ***15*** minutes late to your appointed time we cannot guarantee we'll be able to keep your appointment, subject to doctor's approval.
Patients that present ***outstanding balance*** need to ***liquidate the balance before any appointments can be given.***

WE MUST EMPHASIZE AGAIN THAT OUR FEES ARE BASED ON THE QUALITY OF CARE WE PROVIDE, NOT ON IMAGINARY "UCD" FEES OR WHAT YOUR INSURANCE COMPANY WANTS TO PAY.

I certify that I have read, understood and agree to the terms of this policy and financial agreement. If I miss a payment or do not complete payments as agreed, I understand my account may be sent to collections and will be reflected as such on my credit report and that I will be financially responsible for all additional costs that this may incur.

Parent or Legal Guardian's Signature_____ Date___/___/___

April 30, 2015

Patient's Name:_____ Relationship to patient:_____

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Consent for Dental Treatment

Patient's Name: _____ Date: ____/ ____/_____

Patients must read the marked checked box and initial, also read and sign at the end of the second page.

☐1. **Exams and X-Rays:** I understand that my first visit will require x-rays to complete the examination, diagnostics and treatment. I understand that the work to be performed will be broken into steps called a treatment plan. ***Initials***:_____

☐2. **Drugs and Medications:** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist and staff about all reactions I am aware I have/ had. I understand that drugs may cause drowsiness, fainting or loss of coordination, which can aggravate with the use of alcohol or other drugs. I know and agree that I should not drive any vehicle or make use of any machinery at least 12 hours after taking the medications or until the effect of anesthesia/ sedation is completely worn off. I acknowledge that a drug prescribed may sometimes present risks whereas the infection may linger on and the pain or even an increase of the situations, and therefore causing a resistance and aggravating my condition.
Attn women– I understand the antibiotics may reduce the effectiveness of birth-control pills. ***Initials***:_____

☐3. **Change in the Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination; the common being root canal therapy following routine restorative procedures. I authorize the dentist to make any/ all changes and additions necessary to give me the best possible treatment. ***Initials***:_____

☐4. **TMJ Dysfunction :** I understand that this condition can increase or simply begin as weird cracking sounds on my jaw, blockage, and pain on the articulation of the lower jaw (around the ear) after routine dental treatments where the mouth stays open for a period of time. Sometimes the symptoms of this dysfunction associated with the dental treatment are transitional by nature and perfectly tolerable to most patients, but I understand that some may need further treatment with a specialist and that in this case I am responsible to all costs of this treatment. ***Initials***:_____

☐5. **Fillings:** I understand that it may be necessary to have a more extant filling than the one the dentist originally diagnosed before due to the extent or additional decay which sometimes may compromise the structure of the teeth, leaving no support. In this case additional services may need to be incorporated in order to provide the tooth a normal function. Some of these services may involve Root Canal, Post & Core, Crown. I understand I must be extremely careful when chewing on the fillings (amalgams only- after first 24 hours) to avoid breakage. I understand that sensibility is also a common secondary effect on a tooth recently filled. ***Initials***:_____

☐6. **Teeth Extraction:** Alternatives to extraction have been explained to me (Root Canal, Crowns, and Periodontal Surgery, etc) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (day or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. ***Initials***:_____

☐7. **Crowns, Bridges and Caps: a)** I understand that sometimes it is not possible to match the exact color of the teeth with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized the final opportunity to make change in my crown or bridge (including size, fit, shape and color) will be before final cementation. I was informed that in rare instances cosmetic treatment may need a future root canal, which mostly cannot be anticipated. I understand that cosmetic treatment can affect the tooth surfaces and require modifications in the hygiene process. It is my responsibility to return to the office for the final cementation approximately 20 days after taking the impressions. Excessive delay to return to the office may constitute of: decay, tooth movement, gum disease or bite problems. In this case a new crown, bridge or cap may be needed, therefore, I am aware that additional costs will be implied for this due to the delay of the final cementation. ***Initials***:_____
* **b)** I accept the dentists recommendation to use noble metal instead of basic metal in the fabrication of my crown (s) or bridge (s). ***Initials***:_____
* **c)** I accept to fabricate a fixed bridge or implant instead of a removable appliance. I understand that these services may not be covered by my dental insurance plan. ***Initials***:_____

(Only for certain cases).*

☐8. **Dentures - Full or Partial:** I have been informed that dentures are artificial teeth, and are fabricated of plastic, metal and or porcelain. I have received detailed information about the problems these appliances can cause including tooth looseness, pain, teeth mobility, and possible breakage. I have been informed that the final opportunity to make changes in my full or partial dentures (including size, fit, shape and color) will be at the time of the "try-in" appointment. An immediate denture (following the extraction) can be very disturbing in the beginning and may need several adjustments and relines. A further reline or another set or dentures will be needed, but is not included in the initial costs of the dentures. I have been informed that most dentures need to be relined approximately 3-12 months after the initial placement of the dentures. I understand I its my responsibility to return to the office for the delivery and placement of my appliance and that if I fail to do so may result an incorrect fit. If more than 30 days delay for the delivery a new denture may be necessary and additional costs will imply. ***Initials***:_____

☐9. **Root Canal Therapy:** I understand there is no guaranty that the root canal will save my tooth, and that complications may occur from the treatment. Occasionally, metal objects are inserted through the root, which does not necessarily affect the success of the treatment. I have been informed that in rare instances files and other delicate instruments may break. Therefore, additional surgical procedures will follow the root canal therapy (apicoectomy). The tooth will be sore or sensitive during and following treatment for an variable time. One of the main reasons a root canal may become unsuccessful is due to root fracture, which is difficult to detect. Due to the removal of the nerve the tooth becomes fragile and lacks support. Following the root canal eventually the tooth will need post & core and a crown. ***Initials***:_____

☐10. **Periodontal Treatment:** I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. The success of the treatment partially depends on me. Which means to have a daily strict and effective brushing and flossing, as well as, maintain a regular basis cleaning appointment at the office as oriented by the doctor and including a well balanced diet, also avoiding tobacco products and other recommendations. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. ***Initials***:_____

☐11. **Bleaching:** Bleaching is a procedure either performed at the dental office (approx. 1 hr) or at home with custom-made trays (during approx. 2-4 wks). The shade change varies from person to person and can range (from 1-3 shade from the dental shade guide). Coffee, tea and tobacco will still stain your teeth after the treatment and should always be avoided at least 24 hours after. I understand that I may experience sensibility on my teeth or gum inflammation, which should decrease after the treatment is done. Fluoride can be prescribed as a treatment to decrease sensibility. Carbamide peroxide and other peroxide solutions to bleach teeth are FDA (Food and Drug Administration) approved as oral antiseptics. The use of bleaching agents have not yet been studied. Therefore, the acceptance of the treatment implies that you accept the risks associated with it. It's advisable that pregnant women consult their doctor and bring a written consent to the treatment. ***Initials***:_____

☐12. **Pedo-dontics (Dentistry for Children):** I understand that the following procedures are used as routine in the dental office: **a) Positive Reinforcement:** Which the child is rewarded for cooperating with the treatment with high-five's, hugs, stickers, or prizes. **b) Voice Control:** Which the doctor may change his/her tone of voice to get a disturbing child's attention. **c) Physical Control:** Which may require the parents, or staff's help to detain the child's hands, torso, head and/ or legs. I understand that anesthesia is needed to num the location of the treatment. It is common that the child bite his/ her lip, tongue or cheek without noticing due to the anesthetics and causing a sore (swelling, bruise, skin rupture). I understand the need to return to the office in case the swelling and pain persists for a few days. I also understand that in some cases I may need to return to the office within a period of 3 months after a pulpotomy (nerve extraction) on the primary teeth for an evaluation and perhaps a possible extraction if treatment was not successful. ***Initials***:_____

☐13. During the course of treatment all taken forms of exams (x-rays (2D or 3D), photos, study models) may be outsourced or used for instructional or clinical materials, books, brochures, pamphlets, researches, etc without limits and for any purpose. In this case we maintain all confidential information strictly private (not publishing name, address, phone numbers or any personal data according to HIPAA Standards). All material shall be the exclusive property of this office. I hereby relinquish all rights, title and interest therein. ***Initials***:_____

I understand that Dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and have been informed of any post operatory instructions and fully understand them. I am aware that I should return on the date scheduled for either delivery, stitches removal or continuance of treatment. By signing this consent I hereby formally accept the above statement and affirm all questions have been answered to my satisfaction.

_____	_____	_____/_____/_____
Patient or Legal guardian if under 18yrs old	Relationship to the patient	Date

General Information

Ultimate Comprehensive Dentistry
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1. Patient (About You)

Name: _____ Today's Date: ____/____/____
(last) (first) (middle)

Male Female / □ Mr. □Mrs. □Ms □Dr Birthday: ___ /___/_____ Age:_____
(mm) (dd) (yyyy)

□Child (Minor) □ Single □ Married □ Separated/ Divorced

*Social Security # : _____ *DL#: _____ State:_____

Home Address: _____

City: _____ State: _____ Zip code: _____

Phone #: (_____)_____ *Cell Phone #: (_____)_____

E-Mail: _____

Work:_____ Position / Occupation:_____

Address: _____

City:_____ State: _____ Zip code: _____

Phone #: (_____)_____ E-Mail: _____

General Dentist: (Previous / Present) _____

Address: _____

City:_____ State: _____ Zip code: _____

Phone #: (_____)_____ E-Mail: _____

Other family member seen in our office: _____

To whom may we thank for referring you to our office? _____

Please describe the concerns that have brought you to our office: _____

_____

Emergency contact: Name:_____ Phone #:(_____)_____

Name:_____ Phone #:(_____)_____

2. Spouse (if applicable)

Name: _____ Prefers to be called:_____
(last) (first) (middle)

Birthday: ___ /___/_____ Age:_____
(mm) (dd) (yyyy)

Home Address: (If different from above) _____

City: _____ State: _____ Zip code: _____

Phone #: (_____)_____ Cell Phone #: (_____)_____ _____

E-Mail: _____

Work: _____ Position / Occupation: _____

City: _____ Phone #: _____

3. Account

Person responsible for this account:_____ Relationship:_____
(Only if different from patient information) (Your account will be set up in this name)

Social Security # : _____ / DL#: _____ State:____

Billing Address (Only if different from yours): _____

City: _____ State: _____ Zip code : _____

Contact phone: (_____)_____ Best Time to be reached:_____

Medical History

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1. Patient Today's Date: ____/____/_____

Name: _____ Prefers to be called:_____
(last) (first) (middle)

Male Female / Mr. Mrs. Ms Dr Birthday: ___/___/_____ Age:_____
(mm) (dd) (yyyy)

Who's completing this report : Patient (if adult - over 21)
Patient's Relative (if patient is minor - under 21)
Name:_____ Relationship:_____

2. Physician

Name: _____ Phone #: (_____)_____ Last Visit: ___/____/_____

3. Medical History

› Are you under any medical treatment now?..... Yes No
If Yes, explain:_____
› Do you have history of any major illness?..... Yes No
If yes, explain:_____
› Have you ever been hospitalized?..... Yes No
If yes, explain:_____
› Have you ever received any surgery before?..... Yes No
If yes, explain:_____
› Are you taking any medication? (including: non-prescription's / over-the-counter's / or herbal supplements)..... Yes No
If yes, explain:_____
› Are you allergic to any one of the following substances (Aspirin, Barbiturates, Codeine, Dental Anesthetics, Erythromycin, Iodine, Latex, Penicillin, Sedatives, Sulfa, Tetracycline) or others? (Including Drugs, Food or Environment)..... Yes No
If Yes, list:_____
› Have you experienced any head or facial injuries?..... Yes No
If yes, explain:_____
› **For Women only**:
Are you *or* do you think you could be pregnant?..... Yes No
Are you nursing?..... Yes No
Are you taking birth control pills?..... Yes No
› Are there any medical conditions you feel we should be aware of?..... Yes No
If yes, explain:_____
› Check (√) if you ***have*** or ***had*** any of the following diseases or medical problems:

__Adenoids removed
__Alcohol abuse
__Anemia
__Angina
__AIDS
__Allergy
__Arteriosclerosis
__Arthritis
__Artificial Bones/Joints / valves
__Asthma
__Benign tumors
__Bleeding disorders
__Blood transfusion
__Breathing disorders
__Cancer
__Chemotherapy
__Cleft lip / Cleft Palate
__Chest pain
__Colds (frequents)
__Colitis
__Cough persistent
__Diabetes
__Dizziness / Fainting
__Drug abuse
__Ear tubes placed
__Emotional / Nervous problems
__Emphysema
__Endocrine problems
__Epilepsy / Convulsions
__Genetic disorders
__Glandular problems
__Glaucoma
__Fever Blister
__Headaches (frequent)
__Heart attack
__Heart murmur
__Heart pacemaker
__Heart problems
__Hemophilia
__Hepatitis / Jaundice
__Herpes
__High blood pressure
__HIV+
__Kidney problems
__Leukemia
__Liver disease
__Low blood pressure
__Mental Health problem
__Mitral prolapse
__Periodontal (gum) disease
__Radiotherapy
__Respiratory problem
__Rheumatic / Scarlet fever
__Sleep disorders
__Sinus problems
__Sore Throat (frequents)
__Swollen Ankles
__Swollen neck glands
__Stomach problems
__Stroke
__Thyroid problems
__TMJ (jaw joint problems)
__Tonsils removed
__Trauma
__Tuberculosis (TB)
__Tumors
__Ulcers
__Urogenital disease
__Venereal disease (STD)
__Weight Loss (severe)

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical history.
Signature:_____Date: ____/_____/_____

Dental History

Ultimate Comprehensive Dentistry
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Patient's Name: _____ Date of visit:____/____/____

Please check **Yes** or **No** for your answers:

› Are you experiencing any pain?..... Yes No
› Do you have anything against your smile?..... Yes No
› Are your teeth sensitive to temperature (heat / cold), pressure, sweet or sour?..... Yes No
› Do your gums bleed when you brush or floss?..... Yes No
› Do you need instructions to help take care of your teeth and gums (brushing / flossing / diet)?..... Yes No
› Have you ever had any gum treatment?..... Yes No
› Did you loose any teeth?..... Yes No
› Did you have any difficult extractions?..... Yes No
› Did you have prolonged bleeding following any extraction?..... Yes No
› Have you ever chipped a tooth or injured it badly?..... Yes No
› Do you have any sores or lumps in or near your mouth or neck?..... Yes No
› Did you ever experience any injuries to face, mouth or teeth?..... Yes No
› Did you have any head, neck or jaw injuries?..... Yes No
› Do you have any type of habit (Thumb or Finger sucking / Tongue / Nails, Cheeks, Lips, Pencil or Pen Biting / Bottle / Pacifier)?..... Yes No
› Do you breathe more through your mouth or more through your nose?..... Yes No
› Do you have any pain at joint, ear or side of your face?..... Yes No
› Do you experience "frequent" headaches?..... Yes No
› Have you ever experienced chronic "ringing" in your ears?..... Yes No
› Do you have any difficulty with opening or closing your mouth?..... Yes No
› Do you have any difficulty in chewing?..... Yes No
› Does your teeth or jaw ever feel uncomfortable when you awake in the morning?..... Yes No
› Do you sleep with your hand under your face?..... Yes No
› Are you aware of any clicking or popping in your jaw?..... Yes No
› Are you aware of clenching your teeth during the day (hard biting)?..... Yes No
› Have you ever been told that you grind your teeth sleeping (bruxism)?..... Yes No
› Have you seen an orthodontist in the past?..... Yes No
› Would you object to wearing orthodontic appliances if indicated?..... Yes No
› Has anyone in your family worn braces?..... Yes No
› Did they interrupt or were you unsatisfied with the treatment?..... Yes No
› Would you object appointments during school/work hours?..... Yes No
› Do you play any musical instrument?..... Yes No
› Do you play any sports?..... Yes No
› Is there anything you would like to change in your smile?..... Yes No

IF YES PLEASE EXPLAIN:_____

*The **benefits of Orthodontics** (Braces) are Aesthetics, Health and Function. Ortho is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, and I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature:_____Date: ____/_____/_____

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Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

Your protected health information (individual identifiable information, such as: names, dates, phone/ fax numbers, emails addresses, home addresses, social security numbers) may only be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering treatment to you (i.e., to determine the results of cleanings, surgery, etc);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.)
- To certify, licensing and accrediting bodies (i.e., state dental boards, Dental Institutions etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment, with your permission;
- We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke at any time you may desire.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy right with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Humans Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rule:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or
- Provide an atmosphere that is totally fee of the possibility that your protected health information may be incidentally overhead by other patients and third parties.

This privacy notice (know as HIPAA) is effective as of April 14, 2003. If you have any questions about the information in this Notice please ask for our Privacy Contact Person information at ***(773) 286-0300*** or U.C. Dentistry ucd_office@yahoo.com

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____Today's Date: _____/_____/_____

My signature on this form acknowledges that I have received a copy of U.C. Dentistry's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed and of my rights with respect to my health information.

By signing this form, I consent to *"Ultimate Comprehensive Dentistry"* the use of my patient health information to carry out treatment, payment activities, and health care operations as set forth in their Notice of Privacy Practices.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Signature of Patient's Parent or Legal Guardian Date

I herby give consent to, *"U.C. Dentistry"* to give my patient health information to:

_____ _____
Print Name of Person you authorize Relationship to Patient

_____ _____
Print Name of Person you authorize Relationship to Patient

This consent is effective until revoked by me. I may revoke this consent at any time by providing a written notice of revocation to *"Ultimate Comprehensive Dentistry"*. Revocation of this consent will not affect any action Ultimate Comprehensive Dentistry took in reliance on this authorization before receiving written notice of revocation. Treatment may be declined or discontinued if consent is revoked.

To be completed by *Ultimate Comprehensive Dentistry's staff* in case the form is not signed:

1. Was the patient/ representative provided with a copy of the Notice of Privacy Practices?

   Yes _____ No _____

2. Briefly describe the efforts made to obtain the patient/representative's acknowledgement of receipt of the Notice and explain why the patient/representative was not able or unwilling to sign this form:

   _____

   _____

   _____