Ogden Family Dentistry
Horatio Enacopol, DDS
General and Cosmetic Dentistry

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception - dental insurances was NOT designed to pay for ALL dental care. Most contracts have limits and/or various degrees of co-payments. All deductibles and co-payments WILL be collected at the time treatment is started.

All levels of payment by insurance companies, including allowed fees, usual and customary, are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between you and your insurance company and that the patient bears the ultimate financial responsibility for any costs incurred for treatment.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing or insurance, and once again than you for choosing Ogden Family Dental for your dental care.

Sincerely,

Dr. Enacopol

PLEASE INITIAL __________

9435 W. Ogden Ave. • Brookfield, IL 60513 **Phone: 708-485-0016 • Fax: 708-485-0024**
2015 Ogden Ave. • Lisle, IL 60532 **Phone: 630-737-1455 • Fax: 630-737-1477**
www.ogdenfamilydentistry.com

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FULL NAME ____________________

ADDRESS ____________________

CITY ____________________ STATE __________ ZIP ________

DATE OF BIRTH ____________________ S.S. NUMBER ____________________

EMPLOYER ____________________ HOW LONG? ________

OCCUPATION ____________________ MARITAL STATUS ________

PHONE #'S: HOME ____________________ CELLULAR ____________________

WORK ____________________ EMAIL ____________________ (digital or voice?)

WHOM MAY WE THANK FOR REFERRING YOU? ____________________

IN CASE OF EMERGENCY, CONTACT...

NAME ____________________ RELATION __________ HOME PHONE __________

ADDRESS ____________________ WORK PHONE __________

HEALTH QUESTIONS — HAVE YOU EVER HAD...

	Yes	No		Yes	No		Yes	No
Asthma	❑	❑	Rheumatic Fever	❑	❑	Diabetes	❑	❑
Allergies or Hives	❑	❑	Mitral Valve Prolapse	❑	❑	Blood Transfusion	❑	❑
Tuberculosis	❑	❑	Joint Replacement	❑	❑	Abnormal Bleeding Tendencies	❑	❑
Stroke	❑	❑	Latex Sensitivity	❑	❑	HIV Infection or AIDS	❑	❑
Heart Disease or Attack	❑	❑	Arthritis	❑	❑	Sickle Cell Disease or Trait	❑	❑
Angina Pectoris	❑	❑	Kidney or Bladder Disease	❑	❑	Stomach or Intestinal Ulcers	❑	❑
High Blood Pressure	❑	❑	Hepatitis, Cirrhosis, Liver Disease	❑	❑	Chemo or Radiation Treatment	❑	❑
Pacemaker	❑	❑	Epilepsy or Seizures	❑	❑	Women: Are you Pregnant?	❑	❑
Heart Murmur	❑	❑	Fainting or Dizzy Spells	❑	❑			

PLEASE ANSWER THESE COMPLETELY...

Physician's Name ____________________ Specialty __________

Street ____________________ City __________

Are you being treated by a physician now? ❑ Yes ❑ No For what reason(s)?: ____________________

____

Are you taking any medications at the present time? ❑ Yes ❑ No Which medication(s)?

____

____

Will you possibly take any recreational drugs in the 48 hours before <u>any</u> dental appointment? ❑ Yes ❑ No

Are you sensitive or allergic to any medication? ❑ Yes ❑ No Which medicine(s)? ____________________

____

Have you ever been hospitalized? ❑ Yes ❑ No List reasons and dates: ____________________

____

____

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DENTAL INFORMATION

Do your gums bleed when you brush or floss? ❑ Yes ❑ No

Have your gums receded? ❑ Yes ❑ No

Have you noticed any loose teeth? ❑ Yes ❑ No

Have you had any periodontal (gum) surgery? ❑ Yes ❑ No

Would you say that you have had a ❑ minimal, ❑ moderate, or ❑ major amount of previous dental treatment?

Would you guess that you *need* a ❑ minimal, ❑ moderate, or ❑ major amount of dental treatment now?

Would you say that you have a ❑ low, ❑ moderate, or ❑ high susceptibility to cavities?

Do you have any crowns (caps) or bridgework? ❑ Yes ❑ No About how many? ________

Have you ever had any braces or retainers? ❑ Yes ❑ No

Have you had any permanent teeth extracted (other than wisdom teeth)? ❑ Yes ❑ No About how many? ________

Please describe any other dental information that you feel may be important to us: ____________________

____

____

COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT

RESPONSIBLE PERSON'S FULL NAME ____________________

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ________

RELATIONSHIP TO PATIENT ____________ HOME PHONE ____________ WORK PHONE ____________

EMPLOYER ____________________ HOW LONG? ____________ OCCUPATION ____________

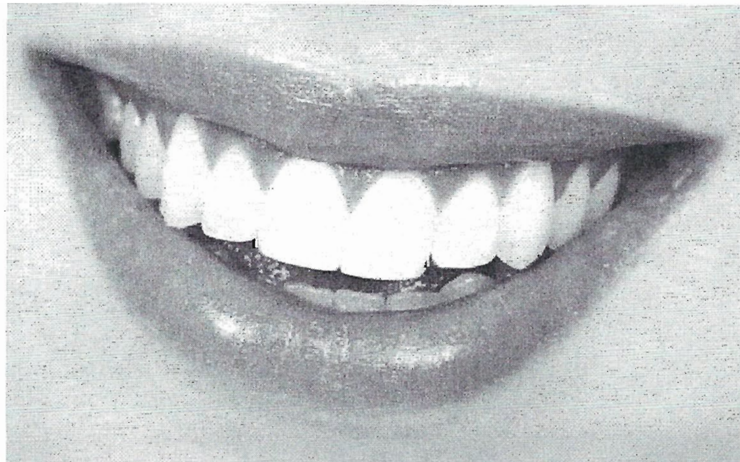
DATE OF BIRTH ____________ S.S. NUMBER ____________ MARITAL STATUS ____________

INSURANCE?

PATIENT'S RELATIONSHIP TO INSURED EMPLOYEE ____________________

FULL NAME OF INSURED EMPLOYEE ____________________

INSURANCE COMPANY ____________________ POLICY # ____________



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES

I acknowledge that I have received the HIPPA notice of Privacy Practices.

___

Print Name of Patient

___

Signature of Patient Date

___

Print Name of Person signing if different than patient

___

If person signing is a representative, describe the basis of the patient's authority to sign on behalf of patient.

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Office Policy

Our practice is dedicated to exceptional patient care and service.

We respect all of our patients' busy schedules and work hard to accommodate your needs while reserving appointment time slots.

We please ask that our patients uphold the same respect for the staff and schedule in this office. Missed and broken appointments create scheduling conflicts for the practice, as well as other patients.

A 24 hour notice is required for all appointments that need to be rescheduled. This allows us to accommodate other patients and adjust the schedule accordingly.

A **$25 fee** will be charged for all missed/failed appointments or those cancelled without a 24 hour notice.

Thank you for your understanding of this policy.

Sincerely,

Dr. Enacopol & Staff

Patient name______________________________
(please print)

Patient Signature__________________________

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