Ogden Family Dentistry
Horatio Enacopol, DDS
and Associates
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 were 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**
www.ogdenfamilydentistry.com

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TELL US ABOUT YOU

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 any 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: _____

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 _____

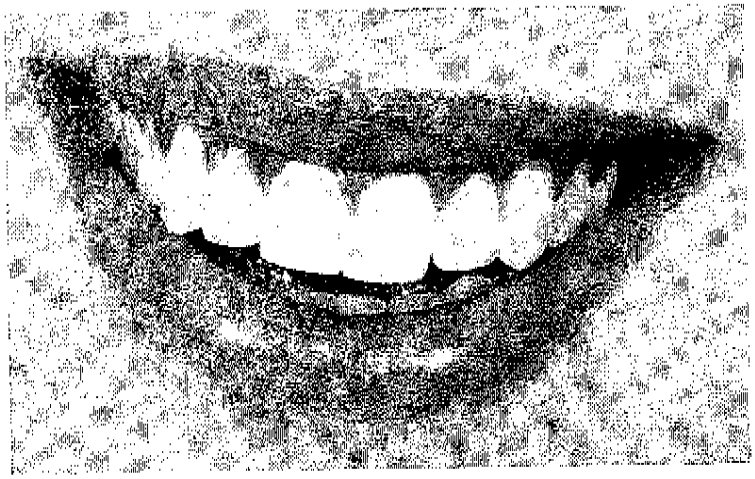
DATE OF BIRTH _____ S.S. NUMBER _____ MARITAL STATUS _____

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 **$40 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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GENERAL INFORMED CONSENT

Patient name:

Welcome to Ogden Family Dentistry - please review this consent carefully!

MEDICAL HISTORY: Please understand that it is important that you give all information about your medical history to your provider. It is important that you inform us of any medicines that you are taking each time that you come to an appointment, as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or with other medications. Please be sure to provide us with a list of any allergies.

RESTORATIONS: I understand that care must be exercised in chewing on fillings and crowns until directed by the doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay or the condition of remaining tooth structure. I understand that sensitivity may occur after a newly placed filling or crown. I also have been informed that in some cases, root canal treatment may be required following a restoration. I realize that a large filling may not be a good long term solution and may lead to tooth breakage that will require further treatment.

TREATMENT CHANGES: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy may be necessary following routine restorative procedures. Also, a filling may be extended to cover additional surfaces if deemed necessary due to decay or fractures not evident upon the original examination. I give my permission to the dentist to make any/all changes and additions as necessary after consultation.

COMPLICATIONS: Although rare, complications can occur from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting),

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would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

I hereby authorize the dental staff of Ogden Family Dentistry to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to allow Ogden Family Denstistry to take any necessary x-rays and perform an examination on me today.

Patient or Parent/Guardian Signature: _____

Date: _____

Doctor Signature: _____

Date: _____

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