FOX RIVER
PERIODONTICS

New Patient Packet

Patient Information

Last Name:	
First Name:	
Initial:	
E-Mail:	
Birthdate:	
Age:	
Social Security #:	
SEX:	
Marital Status:	
Home Address:	
City:	
State:	
ZIP:	
Employer:	
Occupation:	
Home Phone:	
Cell Phone:	
Work Phone:	
EXT:	
Where do you prefer to receive calls?	☐ Home ☐ Work ☐ Cell
When is the best time to reach you? Time:	
Days:	
In the event of an emergency, who should we contact?	
Name:	

Relationship:	
Home Phone:	
Cell Phone:	

Dental Insurance Information

PRIMARY INSURANCE	
Name of Insured:	
Relationship to Patient:	
Insured's Birthdate	
Social Security #	
Employer:	
Insurance Company:	
Group #:	
Employee ID/Cert. #:	
Insurance Co. Address:	
Insurance Phone #:	
SECONDARY INSURANCE	
Name of Insured:	
Relationship to Patient:	
Insured's Birthdate	
Social Security #	
Employer:	
Insurance Company:	
Group #:	
Employee ID/Cert. #:	
Insurance Co. Address:	
Insurance Phone #:	

Referral Information

Whom may we thank for referring you to our practice ?	
Who is your general dentist?	

COVID Vaccine History

Did you receive the COVID vaccine?	◯ Yes ◯ No
If Yes, what was the date of your last dose:	
Which vaccine did you receive (Pfizer, Moderna, etc)?	

Medical History

Are you currently under a physician's care?	◯ Yes ◯ No
If yes, for what?	
Name of Physician:	
Phone:	
Are you taking any medications (prescription or nonprescription)?	◯ Yes (Please use chart) ◯ No
Are you on any blood thinner?	◯ Yes ◯ No
if so name of medication:	
Are you able to take anti-inflammatory pain relievers like Ibuprofen(Advil, Motrin)	◯ Yes ◯ No
Do you need an antibiotic premedication prior to dental visits?	◯ Yes ◯ No
What Pharmacy do you use:	
Street:	
City:	
Phone:	
Medications	
Dosage & Name	
Reason for Taking	
Do you have any of the following?	☐ Anemia ☐ Arthritis / joint disease ☐ Asthma ☐ Diabetes (Type 1 or Type 2) ☐ HIV / AIDS ☐ Kidney disease / chronic kidney failure ☐ Liver disease / hepatitis ☐ Sickle cell disease ☐ Stroke / TIA ☐ Thyroid disease (hyper/hypothyroidism) ☐ Ulcers
-	☐ Alzheimer's Disease ☐ Allergies ☐ Anaphylaxis ☐ Gout ☐ Artificial Heart Valve* ☐ Artificial Joint ☐ Blood Disease ☐ Blood Transfusion ☐ Breathing Problem ☐ Bruise Easily ☐ Cancer ☐ Chemotherapy ☐ Chest Pains ☐ Cold Sores/Fever Blisters ☐ Congenital Heart Disorder ☐ Convulsions ☐ Cortisone Medicine ☐ Drug Addiction ☐ Easily Winded ☐ Emphysema ☐ Epilepsy or Seizures ☐ Excessive Bleeding
	☐ Fainting Spells/Dizziness ☐ Frequent Cough ☐ Frequent Diarrhea ☐ Frequent Headaches ☐ Genital Herpes ☐ Glaucoma ☐ Hay Fever ☐ Head Injuries ☐ Heart Attack/Failure ☐ Heart Murmur ☐ Heart Pace Maker ☐

-	Heart Trouble/Disease ☐ Hemophilia ☐ Hepatitis A ☐ Hepatitis B or C ☐ High Blood Pressure ☐ Hives or Rash ☐ Hypoglycemia ☐ Irregular Heartbeat ☐ Kidney Problems ☐ Leukemia ☐ Low Blood Pressure
-	☐ Lung Disease ☐ Mitral Valve Prolapse ☐ Pain in Jaw Joints* ☐ Parathyroid Disease ☐ Psychiatric Care ☐ Radiation Treatments ☐ Recent Weight Loss ☐ Renal Dialysis ☐ Rheumatic Fever ☐ Rheumatism ☐ Scarlet Fever ☐ Shingles ☐ Sinus Trouble ☐ Spina Bifida ☐ Stomach/Intestinal Disease ☐ Swelling of Limbs ☐ Tonsillitis ☐ Tuberculosis ☐ Tumors or Growths ☐ Venereal Disease ☐ Yellow Jaundice ☐ Other
Other:	
Do you use tobacco?	◯ Yes ◯ No
If Yes:	
Do you use smokeless tobacco?	◯ Yes ◯ No
Do you use controlled substances?	◯ Yes ◯ No
If Yes:	
Women: Are you	☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
Are you allergic to any of the following?	☐ Acrylic allergy ☐ Allergies to Anesthetics ☐ Aspirin allergy ☐ Latex allergy ☐ Local Anesthetics ☐ Metal Allergy ☐ Penicillin allergy ☐ Sulfa allergy
	☐ Other
Other:	
Do you have any health problems that need further clarification?	◯ Yes ◯ No
If yes, please explain:	
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.	
Signature of patient, parent or guardian:	

Financial Arrangements

For your convenience, we offer the following methods of payment.	☐ -Cash ☐ -Personal check ☐ -Credit Card: ☐ -Visa ☐ -MasterCard ☐ -Discover ☐ -American Express ☐ -Care Credit ☐ 12 month interest free and low interest payment plans available

Financial Policy

Patients are expected to pay by cash, check or credit card the day the service is rendered unless specific arrangements have been made in advance with the financial coordinator.

On all accounts over 90 days, the patient will be responsible for all costs of collection if his or her account is in default, including court costs and reasonable attorney fees.

INSURANCE:

Please remember that the patient, not the insurance company, is ultimately responsible for payment of professional services. As a courtesy to you, we will submit to your insurance for your reimbursement. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. Fees charged by our office reflect the high quality of service rendered and will not be adjusted to individual insurance fee structures. The quality of your dental coverage is a direct reflection of the quality of plan selected by your employer. We have no control of individual benefits.

CANCELLATION POLICY:

We can only successfully treat you if you keep scheduled appointments. Dr. Saleh reserves his time for individual patient care. We ask If you are unable to make your appointment, kindly provide notice of cancellation 48 hours prior to your scheduled appointment. Monday appointments must be cancelled by Thursday no later than 1:00 p.m. If the appointment is not cancelled within the stated timeframe, you will be charged $165.00 per half hour of scheduled time wasted, and rescheduling of treatment appointments.

I certify that I have read and understand the above financial policy:

Signature of patient, parent or guardian:	

Authorization and Release

I authorize Fox River Periodontics, to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient, parent or guardian:	

Consent For Use and Disclosure of Health Information

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:
Contact Person: Dr. Islam Saleh, DMD, MS
Telephone: (630) 232-7400
Fax: (630) 232-7590
Address: Fox River Periodontics, 2075 Blackberry Drive, Geneva, IL. 60134

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations, including disclosures via fax. I have received a copy of this office's Notice of Privacy Practices.

Signature:	

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:	☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement ☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other
Other (Please Specify):	

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