FOX RIVER PERIODONTICS

Dental Implants & Periodontics

Office Of Islam Saleh, D.M.D., MS
2075 Blackberry Drive, Geneva, IL 60134
(630) 232-7400

Patient Information

Date

Patient_____ E-mail address_____
Last Name First Name Initial
Birthdate _____Age_____ Social Security #_____
☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Widowed
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 #_____ Cell #_____

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 #or insurance ID#
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 or 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 (circle one)
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 (circle one) if so, name of medication _____

Are able to take an NSAID? (ibuprofen) Yes No (circle one)

DO YOU NEED TO PRE-MED? Yes No (circle one)

What Pharmacy do you use: _____Street_____City_____Phone#_____

Name of Medication	Dosage/ Frequency	Reason for Taking

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV positive
- ☐ Alzheimer's Disease
- ☐ Allergies_____
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ 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
- ☐ Liver Disease
- ☐ 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
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Other:

_____
_____

• Do you use tobacco? ☐ Yes ☐ No_____ • Do you use smokeless tobacco? ☐ Yes ☐ No
• Do you use controlled substances? ☐ Yes ☐ No_____

• Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

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

_____ Date: _____
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 the 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:

_____ Date: _____

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.

_____ Date: _____

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, D.M.D., M.S.
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.

_____
Please Print Name

_____
Signature

_____
Date

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 (Please Specify)