Midway Doctors Center
6715 w. Archer Avenue
Chicago, IL 60638
T: 773-229-1081
F: 773-229-1446
p.liaros6715@gmail.com
www.perioimplantspecialties.com
Peter B. Liaros, D.D.S.

Periodontal and Implant Specialties, Ltd.

Health History

Name: _____Sex: (M) (F) Date of Birth: _____ Age: _____

Home Address: _____ City-State & Zip Code: _____

Home Telephone: _____ Work Telephone: _____ Cell_____

Email: _____ Social Security #: _____

Occupation: _____ Employer: _____

Employer Address: _____ City-State & Zip Code: _____

Spouse Name: _____ Employer: _____

Person to contact in case of emergency not living with you _____ Telephone #_____

Do you have **dental** insurance? (Y) (N) **Please see attached>>>>>>>>>>>>>>>>>>>>>>>>>>**
Who is your general dentist? _____Telephone#_____
Who referred you to our office? _____
Do you clench or grind your teeth? (Y) (N) _____
When were your teeth last cleaned? _____ How often per year? _____
Have you ever had periodontal treatment? (Y) (N) When? _____
What is your chief complaint about your mouth? _____
How would you feel if you had to lose your teeth? _____
Are you a smoker, tobacco or alcohol user? (Y) (N) _____
Do you use any recreational drugs? (Y) (N) Please list: _____
Are you allergic to any medications? (Y) (N) Please list: _____
Are you allergic to any dental anesthetics? (Y) (N) Are you allergic to latex? (Y) (N)
Do you pre-medicate prior to dental cleanings? (Y) (N) Do you take Aspirin daily? (Y) (N)
List all medications you are currently taking, including aspirins and vitamins on next page>>>>>>>

Have you had any of the following?

	Yes	No		Yes	No
AIDS or HIV			**Heart Problems**		
Angina			**Hepatitis**		
Any Complications with Oral Surgery			**High Blood Pressure**		
Arthritis			**Joint Implants**		
Asthma or Respiratory Condition			**Kidney Problems**		
Birth Control Pills			**Liver Disease**		
Bleeding Disorders			**Nervous Disorders**		
Cancer			**Pace Maker**		
Chemotherapy (Presently)			**Pregnant or Breast Feeding (Presently)**		
Diabetes			**Prolapsed Mitral Valve**		
Dialysis			**Rheumatic Fever**		
Emphysema			**Steroids last 2 years**		
Epilepsy Seizures			**Stroke**		
Heart Attack			**Thyroid Disorders**		
Heart Bypass Surgery			**Treatment for Chemical Dependency**		
Heart Murmurs			**Tuberculosis**		

Patient Signature: _____ **Date:** _____

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List of medications taken daily including aspirin and vitamins:

_____

Pharmacy: _____
Pharmacy Address: _____
Pharmacy Phone: _____

INSURANCE INFORMATION

Primary Dental Insurance

Employee Name: _____
Employee DOB: _____
Employer: _____
Insurance Company: _____
Claims Address: _____
Insurance Phone #: _____
Group #: _____
Employee SS#/ ID #: _____

Secondary Dental Insurance

Employee Name: _____
Employee DOB: _____
Employer: _____
Insurance Company: _____
Claims Address: _____
Insurance Phone #: _____
Group #: _____
Employee SS#/ ID #: _____

I understand that I may be responsible for a percentage of or all costs of treatment if insurance is denied.

Patient Signature: _____ Date: _____

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POLICY & FINANCIAL AGREEMENT

Patient Name: _____ **Date:** _____
Please Print

Person Responsible For Finances: _____
Please Print Relationship to Patient

Please note your doctor will be or has prescribed treatment based on your dental/oral health care needs. Any quote will be valid for **90** days.

Finances-Submitting Insurance:

We are happy to assist you in setting a payment plan that best suits your needs. We file dental insurance claims, as a courtesy to our patients. If you have dental insurance we ask that you complete the attached form. Be sure to provide the correct carrier, address, etc. and sign all necessary areas. This will allow us to submit pretreatment estimates prior to your appointments for service as well as a claim upon completion of services for payment. Please note, all pretreatment estimates must be filed with the insurance company prior to beginning treatment which can take as long as 4 to 6 weeks. This is required for patients with preferred provider or managed care plans. Please remember that insurance is a contract between you and your insurance company. Any unpaid balance after 30 days is your patient responsibility regardless of insurance.
We also offer Care Credit as a payment option. Care Credit is an outside financial service for dental / medical use. Please feel free to contact our office for information or visit: www.carecredit.com. **We accept all major credit cards, checks and money orders.**

PERIODONTAL & IMPLANT SPECIALTIES, LTD IS NOT RESPONSIBLE FOR: resolving disagreements over claims or negotiating settlements with your insurance company. You are fully responsible for all fees charged by this office regardless of insurance.

PERIODONTAL& IMPLANT SPECIALTIES, LTD is not a Medicare provider therefore we cannot and do not submit claims to the Medicare Insurance or Medical Insurance.

Cancellations and missed appointments:

A minimum of **72** hours' notice must be given for all surgical appointments, **48** hours for non-surgical appointments. A fee will be charged to your account for all missed appointments. Charges for missed appoints will be identified as such and are not covered by insurance.

Billing:

All patients who have an outstanding balance will be provided with a monthly statement for services rendered along with any payments received by insurance company or patient. All accounts with no activity delinquent / past due for 120 days will be turned over to a third party for collection of account balance and any additional fees if suit is necessary.

Record retention: While HIPAA rules require that our office retains a copy of your records for 6 years, it has been our practice to retain your records for up to 10 years from your last visit.
Please keep a copy of all correspondence sent to you by this office, so that you may have a complete record of your contact with this office.

X_____
Patient name: please print

X_____
Signature: person responsible for finances **Relation to patient**

I agree that I am financially responsible for all treatment received, and missed appointments.

Financial arrangements can be made for patients after treatment has been prescribed.
Scheduling and receiving treatment constitutes acceptance of treatment.
Please note all patient refunds are posted at the end of each month.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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**
- **Communications barriers prohibited obtaining the acknowledgement**
- **Other (please specify)**

_____
_____
_____