Grateful Dental
Jeffrey Wittmus DDS, FADI

Patient Registration

Patient Name:________________________________ Preferred Name:________________________

Birth Date:________________________ Social Security #:________________________

Address:____
Street Unit # (if applicable) City State Zip Code

Home Phone #: _______________________ Cell Phone #: _________________________

Email: ____

Preferred method of contact? (check all that apply) ☐Cell Phone ☐Home Phone ☐Email ☐Text

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Who may we thank for referring you? ____

Who should we contact in case of emergency?

Name: ___________________________________ Phone Number: ____________________

Dental Insurance Information

Insurance Name: ___________________________ Phone #: ___________________________

Employer: _______________________________ Group/Plan ID: ________________________

Subscriber Name: ___________________________ Subscriber date of birth: _________________

Member ID #: _______________________ Subscriber Social Security #: ____________________

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other: ____________________________

Dental Insurance Assignment and Release

I assign directly to Dr. Jeffrey Wittmus all insurance benefits, if any, otherwise payable to me or the insurance subscriber for services rendered on my behalf or my dependants. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Dr. Jeffrey Wittmus to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature for all insurance submissions.

Signature of Patient or Legal Guardian: ___________________________________ Date: ______________

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Jeffrey S. Wittmus, DDS, Ltd.

5315 North Central Avenue | Chicago, Illinois 60630 |773-631-6060 | www.gratefuldental.com

Consent to Contact

By providing a telephone number and/or email address, I expressly consent and authorize the staff at Jeffrey S. Wittmus, DDS, Ltd. to contact me. By providing a telephone number, I expressly consent to the receipt of text messages (for which I may be charged for the text message) and/or phone calls. By providing this express consent, I specifically waive any claim I may have for the making of such calls or text messages, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. & 227. By providing a telephone number, I represent I am the subscriber or owner, or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future, I expressly opt-in to the receipt of all email communications for or related to services provided, my account, and other services such as financial, clinical and educational information including health care coverage and care follow up. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C & 7701, et. Seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I consent to photography, video recording, and radiographs of treatment to be performed for the advancement of dentistry.

I understand that providing a phone number and/or email address is not a condition of receiving services. I also understand that I may revoke my consent to contact at any time by providing written notice.

______________________________	______________________________
Print Patient's Name	Date
______________________________	______________________________
Signature	Date
______________________________	______________________________
Authorized Signature of Parent/Guardian/Accompanying Adult	Date

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Written Financial Policy

Thank you for choosing Dr. Wittmus as your Dental Care Provider. Our primary mission is to deliver the best and most comprehensive dental care possible. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, or Discover Card

We offer a 10% senior courtesy accounting adjustment to patients who pay **in full** for their treatment with **check or cash** prior to completion of care for treatment plans of $900 or more.

- NO INTEREST[1] Payment Plans[2] from **CareCredit.**
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available.
    - No annual fees or pre-payment penalties.

Please note: This office requires payment at the time of your treatment.

For larger, more comprehensive treatment plans of $2,000 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Your non-covered patient portion is due at the time of service.

Each month after 90 days that a payment is not received, a 2% rebilling fee will be charged. Checks returned for insufficient funds will be charged $35 per occurrence.

Appointment Cancellation Policy

Cancelling or missing an appointment is a loss to 3 people, the doctor who set aside time to see you, the assistant who has prepared for your appointment, and the patient who could’ve been seen during the allotted time. Patients who miss or cancel appointments without **48-hr notice** will be charged $60.00 per incident. **Appointments will not be rescheduled until the cancellation charge has been paid.**

☐ I verify that I have read and understand the financial and appointment cancellation policies.

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Patient, Parent or Guardian Signature Date

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2] Subject to credit approval.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Social Security #: _________ - ______ - __________

SECTION B: 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 Dr. Jeffrey S. Wittmus.

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.

SIGNATURE

I, ______________________, have had 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.

Signature: _______________________________Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________________________

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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HEALTH HISTORY FORM

Dental Information

What is the reason for your dental visit today? ____________________

How do you feel about your smile? ____________________

How often do you brush your teeth? __________ How often do you floss? __________

Do you use an electric toothbrush? __________Type of toothpaste: __________

Do you use mouthwash? __________ Type of mouthwash: __________

Date of your last dental visit: __________ What was done at this visit? __________

Former Dentist: __________ Phone #:__________

May we contact this office for any x-rays and medical records we may need? ☐Yes ☐No

For the following questions, please mark (x) for your responses.

Question	Y N	Question	Y N
Do your gums bleed when you brush or floss?............................	☐ ☐	Do you have earaches or neck pain?.............	☐ ☐
Are your teeth sensitive to cold, hot, sweets, or pressure?..........	☐ ☐	Do you have any clicking popping, or discomfort in the jaw?....................................	☐ ☐
Does food or floss catch between your teeth? ……………………	☐ ☐	Do you brux or grind your teeth?....................	☐ ☐
Is your mouth dry?..	☐ ☐	Do you have sores or ulcers in your mouth?...	☐ ☐
Have you had any periodontal (gum) treatments?.......................	☐ ☐	Do you wear dentures or partials?..................	☐ ☐
Have you had any orthodontic (braces) treatment?.....................	☐ ☐	Have you had a serious injury to your teeth or mouth?..	☐ ☐
Have you had any problems associated with previous dental treatment?...	☐ ☐	Do you snore?..	☐ ☐
Is your home water supply fluorinated?.......................................	☐ ☐	Do you wear a CPAP appliance?....................	☐ ☐
Do you drink bottled or filtered water?...	☐ ☐	Do you experience daytime fatigue? ..……….	☐ ☐
If yes, how often? ☐Daily ☐Weekly ☐Occasionally			
Are you currently experiencing dental pain or discomfort?..........	☐ ☐	Are you a mouth breather?.............................	☐ ☐

Medical Information

Question	Y N	*If yes, please elaborate/list in the spaces below:*
Are you under a physician's care now?..	☐ ☐	
Have you ever been hospitalized or had a major operation?.........	☐ ☐	
Have you ever had a serious head or neck injury?........................	☐ ☐	
Do you take, or have you taken, Phen-Fen or Redux?..................	☐ ☐	
Have you ever taken Fosamax, Boniva, Actonel, or other medications containing bisphosphonates?..............................	☐ ☐	
Are you on a special diet?..	☐ ☐	
Have you ever had a blood transfusion?..	☐ ☐	
Are you taking any medications, pills, or drugs?............................	☐ ☐	

Are you allergic to any of the following? *Please mark all that apply:*

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Latex ☐ Metal ☐ Acrylic

☐ Other ____________________

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

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Do you have, or have you had, any of the following? *Please mark all that apply:*

AIDS/HIV Positive……………☐	Cortisone Medicine…………☐	Hepatitis A………………☐	Recent Weight Loss…………☐
Alzheimer's Disease…………☐	Diabetes…………………….☐	Hepatitis B or C……………☐	Renal Dialysis………………☐
Anaphylaxis…………………☐	Drug Addiction………………☐	Herpes Simplex A or B………☐	Rheumatic Fever……………☐
Anemia…………………………☐	Easily Winded………………☐	High Blood Pressure…………☐	Rheumatism…………………☐
Angina…………………………☐	Emphysema…………………☐	High Cholesterol…………… ☐	Scarlet Fever…………………☐
Arthritis/Gout………………☐	Epilepsy or Seizures…………☐	Hives or Rash………………☐	Shingles……………………☐
Artificial Heart Valve……… ☐	Excessive Bleeding…………☐	Hypoglycemia………………☐	Sickle Cell Disease…………☐
Artificial Joint………………☐	Excessive Thirst……………☐	Irregular Heartbeat…………☐	Sinus Trouble………………☐
Asthma…………………………☐	Fainting Spells/Dizziness……☐	Kidney Problems……………☐	Spina Bifida…………………☐
Blood Disease………………☐	Frequent/Persistent Cough…☐	Leukemia……………………☐	Stomach/Intestinal Disease…☐
Blood Transfusion……………☐	Frequent Diarrhea……………☐	Liver Disease………………☐	Stroke…………………………☐
Breathing Problems…………☐	Frequent Headaches…………☐	Low Blood Pressure…………☐	Swelling of Limbs……………☐
Bruise Easily…………………☐	Glaucoma……………………☐	Lung Disease………………☐	Thyroid Disease……………☐
Cancer…………………………☐	Hay Fever……………………☐	Mitral Valve Prolapse………☐	Tobacco Habit………………☐
Chemotherapy………………☐	Heart Attack/Failure…………☐	Osteoporosis………………☐	Tonsillitis……………………☐
Chest Pains…………………☐	Heart Murmur………………☐	Pain in Jaw Joints…………☐	Tuberculosis…………………☐
Cold Sores/Fever Blisters……☐	Heart Pacemaker……………☐	Parathyroid Disease…………☐	Tumors or Growths…………☐
Congenital Heart Disorder……☐	Heart Trouble/Disease………☐	Psychiatric Care……………☐	Ulcers…………………………☐
Convulsions…………………☐	Hemophilia…………………☐	Radiation Treatment…………☐	Venereal Disease……………☐
			Yellow Jaundice……………☐

Do you have, or have you had, any illnesses or medical conditions not listed above? If so, please list them below:

____

____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent, or Guardian:

____ **Date:**________________________