COVID-19 Pandemic Dental Treatment Consent Form I, knowingly and willingly consent to dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Given the current limits in virus testing, it is impossible to determine who has it and who does not have COVID-19.

● I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

● I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

● Fever

● Shortness of breath

● Dry cough

● Runny nose

● Sore throat, I understand that air travel significantly increases the risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry.

● I verify that I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19.

● I verify that I have not traveled within the United States by commercial airline, bus, or train within the past 14 days.

-----> _____ (Initial)

-------> Name _____ Date _____

-------> Signature: _____

------->Childs name _____

_____

COUNTRYSIDE DENTAL

Patient Information

Countryside Dental
472 W Half Day Rd
Buffalo Grove, IL 60089
Phone: (847) 634-2525
Fax: (847)634-2860
CountrysideDentist.com

Please complete this form in ink and print your answers.
If you have any *questions, please do not hesitate to ask one of our staff.*

Name _____ Date _____
First Name MI Last Name

Address _____

City _____ State _____ Zip _____

Birthdate _____ □ Male □ Female Home Phone# (____) _____

Cell Phone# (____) _____ Work Phone# (____) _____

Where do you prefer to take calls: □ Home □ Cell □ Work

May we contact you by E-mail? □Yes □ No E-mail Address _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor

Social Security # _____ Drivers License # _____ State _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Workplace _____

If you are a student, name of school _____ City/State _____

How did you hear about our office? _____

Who may we thank for referring you? _____

Closest relative not living with you & their phone number _____

Emergency Contact _____ Phone# (____) _____

Responsible Party *(if patient is a minor)*

Name of person financially responsible for this account _____

Relationship to patient _____ Phone # (____)_____

Address of Employer _____

City _____ State _____ Zip _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate _____ Subscriber Social Security # _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Insurance Co. _____ Group # _____

Subscriber ID # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Company Phone # (____) _____

Do you have additional dental insurance? □ Yes □ No If yes, Please complete the following:

Insurance Co. _____ Group # _____

Subscriber ID # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Company Phone # (____) _____

Dental History

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Buffalo Grove, IL 60089
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CountrysideDentist.com

Name _____ Date _____
First Mi. Last

Reason for Today's Visit _____

Date of last exam _____ Date of last dental X-rays _____

Date of your last dental cleaning _____ How often do you brush? _____

What type of toothbrush do you use? □ regular □ electric

How often do you floss? _____

Do you use mouthwash or some other type of rinse? □ Yes □ No Describe _____

Do you have any dental problems now? □ Yes □ No Describe _____

_____

Have you ever had an upsetting dental experience? □ Yes □ No Describe _____

_____

Have you ever had: □ Orthodontics □ Periodontal Surgery □ Oral Surgery

Please check any of the following conditions that apply to you:

□ Bad Breath
□ Bleeding Gums
□ Clicking or Popping jaw
□ Food Collection between Teeth
□ Tired jaws in the morning
□ Difficulty in opening or closing the mouth
□ Grinding Teeth
□ Loose Teeth or Broken Filling
□ Periodontal Treatment
□ Sores or Growths in Your Mouth
□ Sore Facial Muscles
□ Sensitivity to Hot
□ Sensitivity to Cold
□ Sensitivity When Biting
□ Sensitivity to Sweets
□ Wear a Night Guard
□ Headaches or Neck Aches
□ Snoring

Are you happy with the appearance of your teeth? □ Yes □ No If no, please describe

_____

□ Other: _____

_____

Previous Dentist's Name _____

COUNTRYSIDE DENTAL

Medical History

Countryside Dental
472 W Half Day Rd
Buffalo Grove, IL 60089
Phone: (847) 634-2525
Fax: (847)634-2860
CountrysideDentist.com

Patient _____

Physician _____ Date Of Last Visit _____

Please list all medications you are currently taking with dosage:

_____

_____

List all allergies:

_____

Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Indicate which of the following you have had, or have at present? (Check all that apply).

□ AIDS	□ Circulatory Problems	□ Hepatitis	□ Scarlet Fever
□ Allergies or Hives	□ Cold Sores	□ High Blood Pressure	□ Shortness of Breath
□ Anemia	□ Cortisone Treatments	□ HIV Positive	□ Sinus Problems
□ Anxiety Problmes	□ Cough, Persistent	□ Jaw Pain	□ Skin Rash
□ Arthritis, Rheumatism	□ Cough up blood	□ Kidney Trouble	□ Stroke
□ Artificial Heart Valves	□ Diabetes	□ Latex Sensitivity	□ Swelling of Feet/Ankles
□ Artificial Joints	□ Epilepsy	□ Liver Disease	□ Thyroid Problems
□ Asthma	□ Fainting	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Back Problems	□ Glaucoma	□ Neurological Problems	□ Tonsillitis
□ Blood Disease	□ Headaches	□ Pacemaker	□ Tuberculosis
□ Cancer	□ Heart Murmur	□ Psychiatric Care	□ Ulcers
□ Chemical Dependency	□ Heart problems	□ Radiation Treatment	□ Venereal Disease
□ Chemotherapy	□ Hemophilia	□ Rheumatic Fever	

□ Other: _____

_____

Please describe any positive responses from the list above:

_____

_____

Do you smoke? □ Yes □ No Describe _____

Do you use alcohol? □ Yes □ No Describe _____

Do you use recreational drugs? □ Yes □ No Describe _____

Have you had surgery or been hospitalized in the last 5 years? □ Yes □ No Describe

_____

_____

Dentist's Signature _____ Date: _____

History Review _____ History Review _____ History Review _____ History Review _____

COUNTRYSIDE DENTAL

472 Half Day Rd.
Buffalo Grove, IL. 60089
(847)634-2525

OFFICE FINANCIAL POLICY

ACCOUNT STATEMENTS

After you have paid the estimated portion of your fees, we will bill the insurance company. If your insurance company pays less than their estimated portion, we will notify by an invoice regarding the balance that is due on your account. You are responsible for the balance due that is not paid by your dental insurance. Reminder, dental insurance companies have a yearly deductible that you are responsible for.
Please contact your insurance company regarding your dental benefits coverage.
If there is a balances on your account that is not paid after 90 days (3 months), a Final Notice letter will be mailed to you, payment is due within 10 days. If no payment has been received, the account will be turned over to the collection agency.

It is customary for us to receive payment in full at the time of your first visit to our office, as well as for emergency visits, recall cleaning visits, routine procedures under basic and major services unless dental insurance has been provided and verified.
When extensive treatment is planned, we realize it may be necessary to make other arrangements. Please discuss any payment arrangements with the Office Manager prior to your treatment.

Collection Agency Fees

In addition to the principal **amount owed, I also agree to pay 30% of the unpaid balance if my account is turned over to a collection agency or attorney in an effect to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collections agency fees and attorney fees.**
The arrangement is established under an agreement between a collection agency and a creditor to collect the debt.
The fee is paid by a debtor pursuant to a contract between the creditor and debtor.

By signing this agreement, I certify that I have read the entire financial policy and agree to all terms and conditions.

----> Patients Name: _____ Date:_____

---> Patient/ Parent or Guardians Signature: _____

Payment is due on account within 30 days for balances

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PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

COUNTRYSIDE DENTAL

*** 48 HOURS NOTICE****

CANCELLATION/RESCHEDULING & MISSED APPOINTMENT POLICY

We strive to render excellent dental care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our Policy is as follows: We require that you give our office 48 hours' notice if you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment.

A fee of $50.00 for hygiene appointment and $100 for treatment or Periodontal Scaling and Root Planing (SRP) appointment. This fee cannot be billed to your insurance company and will be your direct responsibility.

No records be transferred without the payment of this fee.

If you have any questions regarding this policy, please let our Office Manger know and she will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, (PATIENT FULL NAME) _____ received a copy of Countryside Dental Appointment Cancellation Policy.

SIGNATURE OF PATIENT: _____

SIGNATURE OF GUARDIAN: _____

CHILD'S NAME: _____

CHILD'S NAME: _____

CHILD'S NAME: _____

Credit Card on File Authorization

Please complete this form if you would like Countryside Dental to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment.

Information to be completed by the card holder: Please PRINT

Card Holder Name: _____

Card Number: _____

Expiration date: _____

Card Type:

Visa___ Mastercard___ American Express___ Discover___ Care Credit___ HSA___

Security Code: _____

Billing Zip code_____

Street Address Number: _____

E-Mail_____

I, _____, authorize Countryside Dental to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

In the event the credit card expiration date has expired or the credit card has been declined, an invoice will be mailed to you and balance is due within 30 days. Initial _____

Cardholder Signature_____ Date_____

COUNTRYSIDE DENTAL

Dear Patient,

Your dental records and x-rays are a valuable part of our office. We are required to keep your records in our office. Duplicate records will be sent directly to another Dentist or released to the patient. Due to patient confidentially laws, the release of records require submittal of the form below. We thank you for your understanding in this matter.

*****RECORDS RELEASE OF X-RAYS/ RECORDS ****

Fax number 847-634-2860 or email to: smile@countrysidedentist.com

******* COMPLETE THE INFORMATION BELOW*****

→ **Today's Date: _____**

My permission is granted to Countryside dental to release records and xrays concerning the dental treatment of from the onset of treatment to the above date.

→ **Patients Name_____**

I expressly release from liability Countryside Dental and Dr. Natalya Nagornaya from any and all liability aring from compliance with this request and disclosure of the requested information. I acknowledge that I am still responsible for any and all payment balance on my account with Countryside Dental.

→ **Patient OR Legal Guardian Signature_____**

→ **Address, City, State, Zip_____**

→ **Printed Email address:_____**

Send my xrays information to the following Dentist:

Doctor Name_____

Address, City, State, Zip_____

Printed Email address:_____