"We'll take the 'bite' out of seeing the dentist"

Brian P. Danielewicz, D.D.S.
Smile Doctors

424 Lake Street
Antioch, Illinois 60002
847.838.9944

740 Florsheim Drive
Libertyville, Illinois 60048
847.816.3377

7003 39th Avenue
Kenosha, WI 53142
262.657.7942

www.drdandds.com

www.kenoshadentist.com

Name _____

Address _____

City _____ State _____ Zip _____

E-mail _____

Employer _____ Driver's License _____

Birth Date _____ Height _____ Weight _____

Phone Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? _____

Cell (____) _____

Emergency: Name _____ Phone (____) _____

INSURANCE

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone (____) _____ Group # _____

Relation to Patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone (____) _____ Group # _____

Relation to Patient _____

INSURANCE AUTHORIZATION STATEMENT

I hereby authorize payment directly to Brian Danielewicz, DDS, LTD of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Brian Danielewicz, DDS, LTD to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

IF PATIENT IS UNDER 18

Responsible Party _____ Relationship to Patient _____

Address _____
Street City State Zip

Phone (____) _____

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OTHER INFORMATION

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

MEDICAL HISTORY AND INFORMATION

CONDITIONS

- ❒ Abnormal Bleeding
- ❒ Alcohol Abuse
- ❒ Allergies
- ❒ Anemia
- ❒ Angina Pectoris
- ❒ Arthritis
- ❒ Artificial Heart Valve
- ❒ Asthma
- ❒ Blood Transfusion
- ❒ Cancer
- ❒ Chemotherapy
- ❒ Colitis
- ❒ Congenital Heart Defect
- ❒ Diabetes
- ❒ Difficulty Breathing
- ❒ Drug Abuse
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Facial Surgery
- ❒ Fainting Spells
- ❒ Fever Blisters
- ❒ Frequent Headaches
- ❒ Glaucoma
- ❒ HIV + AIDS
- ❒ Heart Attack
- ❒ Heart Murmur
- ❒ Heart Surgery
- ❒ Hemophilia
- ❒ Hepatitis A
- ❒ Hepatitis B
- ❒ Hepatitis C
- ❒ High Blood Pressure
- ❒ Joint Replacement
- ❒ Kidney Problems
- ❒ Liver Disease
- ❒ Low Blood Pressure
- ❒ Mitral Valve Prolapse
- ❒ Pace Maker
- ❒ Psychiatric Problems
- ❒ Radiation Therapy
- ❒ Rheumatic Fever
- ❒ Seizures
- ❒ Sexually Transmitted Disease
- ❒ Shingles
- ❒ Sickle Cell Disease
- ❒ Sinus Problems
- ❒ Stroke
- ❒ Thyroid Problems
- ❒ Tuberculosis
- ❒ Ulcers

ALLERGIES

- ❒ Aspirin
- ❒ Codeine
- ❒ Dental Anesthetics
- ❒ Erythromycian
- ❒ Latex
- ❒ Metals
- ❒ Penicillin
- ❒ Sulfa
- ❒ Tetracycline

Other

Y	N	
❒	❒	Do you smoke or use tobacco?

If Female

Y	N	
❒	❒	Are you taking Birth Control Pills?
❒	❒	Are you pregnant? If yes, # of weeks _____
❒	❒	Are you nursing?

Please list any medications you are currently taking: _____

_____

TREATMENT AUTHORIZATION FORM

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Patient's Signature _____ Date _____

If patient is a child or requires a guardian:

Parent/Guardian Signature _____ Date _____

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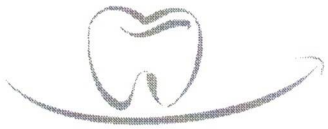

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CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or by credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1-1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said serves are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. We accept cash, checks (for established patients), debit cards, Flex or Health Spending Accounts, and all major credit cards.

Optional Payment Terms:

1. Major Service Cash Discount: We offer a 5% accounting courtesy for all treatment this is paid in full (cash or check) over $1000.00 at the time of service. This is not available is the services are being billed to an insurance company.
2. Major Service Payment Option 2: We offer a two-payment option for Crown, Bridge, Implant, and Denture treatment. We ask that you pay one-half of your portion at the first appointment and the second half at the delivery date.

Dental HQ:

A membership Plan allowing for low monthly payments or 1 annual payment to keep dental care affordable. There is no deductible, no claim forms, no yearly maximum, no dental services excluded and the eligibility is immediate upon signing up. Our office has designed a plan for people without dental insurance or for anyone who is tired of paying premiums and getting less than what they are paying for. Your preventative care is included at no additional cost (cleaning, x-rays, exam) and you receive significant savings on a wide range of dental services.

CareCredit:

We are pleased to accept CareCredit, one of America's leaders in patient healthcare financing. CareCredit lets you begin your treatment right away and pay for it over time with monthly payments that can easily fit into your budget. Applications available in the office, online (www.carecredit.com) or by telephone (866-893-7864).