Submit by Email | Print Form

Instructions

Please fill out the form as completely as possible. When you're done, you have two choices. Click the button below to either:

1) Click the "Submit by Email" button and send this document to our office; or
2) Print the form and bring it with you to your appointment

Nolan Freund Dental Professionals
Michael J Nolan, DDS Chad W Freund, DDS

3633 W Lake Ave #414
Glenview, IL 60026

www.nolanfreund.com 847-724-6222

Welcome

Submit by Email | Print Form | Reset Form

Patient Information

SSN _____ Current Date _____

First Name _____ Initial ____ Last Name _____

Address _____

City _____ State ____ Zip Code _____

Sex _____ Marital Status _____ Birthday _____

Occupation _____

Employer _____

Contact Information

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:
(Specify someone who does not live in your household)

Name _____

Home Phone _____

Relationship _____

Questionnaire

Whom may we thank for referring you?

What is important to you when choosing your new dentist?

Are you satisfied with your tooth appearance?	Yes	No
Are you satisfied with your tooth color?	Yes	No
Do you feel your teeth are crowded?	Yes	No
Do you feel your teeth are poorly aligned?	Yes	No
Do you feel your teeth are protruding?	Yes	No
Do you suffer from dental decay in your front teeth?	Yes	No
Do you have non-esthetic front teeth restorations?	Yes	No
Do you have fractures in your front teeth?	Yes	No
Are you hiding your teeth while smiling?	Yes	No

Dental Insurance

Relationship to Patient? _____

Insurance Company _____

Subscriber's Name _____

Subscriber's Birthday _____ SSN _____

Group # _____

Medications

List any medications you are currently taking and the correlating diagnosis:

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Skin reaction to jewelry
- ☐ Any known metal allergies
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (Specify)

Dental History

Reason for Today's Visit

Former Dentist _____

City/State _____

Date/Last Visit _____

Date/Last Dental X-Rays _____

Please select "Yes" or "No" to indicate if you have had any of the following:

Bad breath	◯ Yes ◯ No	Burning sensation on tongue	◯ Yes ◯ No
Bleeding Gums	◯ Yes ◯ No	Chew on one side of mouth	◯ Yes ◯ No
Blisters on Lips or Mouth	◯ Yes ◯ No	Smoking or Tobacco use	◯ Yes ◯ No
		Clicking or popping jaw	◯ Yes ◯ No
		Dry mouth	◯ Yes ◯ No
		Fingernail biting	◯ Yes ◯ No
		Food collection between teeth	◯ Yes ◯ No
		Grinding Teeth	◯ Yes ◯ No
		Loose teeth or broken fillings	◯ Yes ◯ No
		Mouth breathing	◯ Yes ◯ No
		Mouth pain, brushing	◯ Yes ◯ No
		Orthodontic treatment	◯ Yes ◯ No
		Pain around ear	◯ Yes ◯ No
		Periodontal treatment	◯ Yes ◯ No
		Sensitivity to cold	◯ Yes ◯ No
		Sensitivity to heat	◯ Yes ◯ No
		Sensitivity to sweets	◯ Yes ◯ No
		Sensitivity when biting	◯ Yes ◯ No
		Sores or growths in your mouth	◯ Yes ◯ No
		How often do you brush?	_____
		How often do you floss?	_____

Health History

Physician's Name _____ City/State _____ Date/Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine?) ◯ Yes ◯ No

Please select "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Arthritis, Rheumatism	◯ Yes ◯ No	Fainting or dizziness	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No
Artificial Heart Valves	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Artificial Joints	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Shortness of breath	◯ Yes ◯ No
Back Problems	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No
Bleeding abnormally, with extractions or surgery	◯ Yes ◯ No	Hepatitis Type_____	◯ Yes ◯ No	Skin rash	◯ Yes ◯ No
		Herpes	◯ Yes ◯ No	Special diet	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Swollen feet or ankles	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	Jaw Pain	◯ Yes ◯ No	Swollen neck glands	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Thyroid problems	◯ Yes ◯ No
Circulatory Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Congenital Heart Lesions	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cortisone Treatments	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tumor or growth on head or neck	◯ Yes ◯ No
Cough, persistent or bloody	◯ Yes ◯ No	Nervous Problems	◯ Yes ◯ No	Ulcer	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Weight loss, unexplained	◯ Yes ◯ No
Do you wear contact lenses?	◯ Yes ◯ No				

Women Only:

Are you pregnant?	◯ Yes ◯ No	Due date _____
Are you nursing?	◯ Yes ◯ No	
Taking birth control pills?	◯ Yes ◯ No	

NOLAN & FREUND
DENTAL PROFESSIONALS
CULTIVATING PATIENT RELATIONSHIPS FOR GENERATIONS

FINANCIAL AGREEMENT

Thank you for choosing Nolan and Freund Dental Professionals. As a fee for service practice, our primary objective is to deliver the best dental care possible.

We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients' financial capabilities.

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several convenient payment options:

Cash,Check,Debit Card

Pre-payment discount available for services greater than $500

Credit Card

Visa, Amex
MasterCard
Discover

Half up front, Half before completion

For your convenience
$500 minimum purchase

0% CareCredit Financing

For qualified applicants
$500 minimum purchase

Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly, therefore, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.

Please be aware that we will always review your proposed treatment and answer any questions related to your personal financial responsibility and insurance benefits. **We must emphasize that as dental care providers, our relationship is with you, not with your insurance company.** Please be aware that:

- Your insurance contract is between you, your employer, and the insurance company. **We are not a party to that contract.**
- Our fees are considered to fall within the acceptable range by most companies and therefore, are covered to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (Such as 50% or 80%) of the "UCR" defined as usual, reasonable, and customary fees for this region. However, we cannot guarantee that our fees will always fall within this range.
- **Not all services are a covered benefit in all contracts.** Some employers and insurance companies arbitrarily select particular services that are not covered by their benefit plan.

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3633 W LAKE AVE SUITE 414
GLENVIEW, IL 60026
847.724.6222 OFFICE 847.724.6263 FAX

We encourage you to read your insurance policy so you are fully aware of the benefits and any limitations that were negotiated by your employer with your insurance company.

Please acknowledge your understanding of the following by signing below:

- **Payment is due at the time services are rendered.**
- As a courtesy service to you, **we will submit your insurance claim for your direct reimbursement.** We make every effort to submit claims accurately using the fastest means available.
- **Cash, Check, Visa, MasterCard, Discover Card, and American Express** are always welcome.
- For your convenience, we offer extended financing through CareCredit, which provides an **array of financing options, including interest-free payments for comprehensive treatment plans**. Inquire for details.
- **If you wish to have the insurance company pay us first, we require a credit card on file with authorization to charge the remaining balance once your insurance company processes the claim.**
- **Returned checks are subject to a $30 returned check fee.**
- **Cancellations require 48 hour notice. Appointments canceled within 48 hours will be charged a $100 missed appointment fee charged to your credit/debit card on file.**
- **No show appointments will be charged a $100 missed appointment fee charged to your credit/debit card on file.**
- Outstanding balances **older than 60 days are subject to an interest charge of 1.5% per month.**
- **Outstanding balances older than 90 days may be relinquished to a collection agency.** In the event that the balance is sent to a collection agency, all collection fees, attorney fees and court costs incurred by Nolan Freund Dental Professionals will be added to the amount owed.

Please feel free to contact us with any questions. We are here to help you.

Thank you for your commitment to our practice. We look forward to seeing your smile and working together to provide a caring and comfortable environment for your optimal oral health care.

Print Name: _____

Signature: _____ **Date:** _____

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Recurring Payment Authorization Form

Upon processing of your insurance claim, schedule your payment to be automatically charged to your Visa, MasterCard, American Express or Discover Card. You can also use your HSA or FSA card! Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount outstanding on your balance. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I, _____ authorize Nolan Freund Dental Professionals to charge my credit card indicated below for the outstanding balance on my account.

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Credit Card

_ Visa _ MasterCard

_ Amex _ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Nolan Freund Dental Professionals in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Print Form

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in treatment directly and indirectly.
- Obtain Payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care questions. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so even though the Notice of Privacy Practices was received as documented below:

Date _____ Initials _____ Reason _____

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