Smiles of Lombard, P.C.
845 S. Main St. Suite 201 Lombard IL 60148
Ph: 630-376-6176 Fax: 630-519-4184

WELCOME!

Thank you choosing our dental healthcare team.
We will strive to provide with the best possible dental care.
To help us meet all your dental healthcare needs, please read this form completely.
If you have any questions or need assistance, please ask us. We will be happy to help.

- Cancellation fees.
  All our time is reserved exclusively for you. If you will not be able to attend the appointment, please notify us at least 24h before scheduled time. Otherwise you account will be charge in the amount of $50.00
- Co-payment
  Co-payment is expected to be paid by patient at the time of the service, if you have dental insurance (depending on your policy benefits and coverage)
- Prosthetic Services
  Payment is expected in full before delivery of your prosthetic work. Upon your first scheduled appointment the down payment will be charged in the amount od 50% of the fee.
- Returned Check Fee
  There will be a charge to your account in the amount of $35.00 for any returned check resulting in insufficient funds.
- Collection Policy
  If the amount due is not paid within 60 days of the last statement, or other arrangements has not been made, your account will be forwarded to collection agency. Your account will be charged additional 35% of amount due to cover reasonable collection fees and reasonable attorney fees.
- All X-rays, paperwork documentation, and electronic documentation is a legal property of our office. Patient has the right to receive copies f such document upon additional fee. Electronic x-rays can be forwarded to secured patient's email address or another dental provider upon written request.

I agree to pay reasonable attorney fees and collection fees if my account is placed for collection.

_____ _____
Signature Patient, Parent, Guardian or Personal Representative Date

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PATIENT INFORMATION

Name _____ Birthday: _____ SS# Please provide in person or via phone. _____
Address _____ City _____State _____ Zip _____
Sex: □M □F □ Married □ Widowed □ Single □ Minor □ Separated ■ Divorced □ Partnered for ___years
Home Phone# _____ Cell Phone _____ Cell phone #2 _____
Employer _____ Work Phone# _____
Employer Address _____ City _____ State _____ Zip _____
Spouse / Partner Name _____ Employer _____ Work Phone _____
Who may we thank you for referring you? _____
Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY

Name of person
Responsible for this Account: _____ Relation to Patient: _____
Address: _____ Home Phone _____
Birthday _____ Currently a patient in our office: □ Yes □ No
Employer _____ Work Phone _____
E-Mail _____ Cell Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to patient _____
Birthday _____ SS# Please provide in person or via phone. _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible _____ How much have you used _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to patient _____
Birthday _____ SS# Please provide in person or via phone. _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible _____ How much have you used _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former Dentist _____ Date of last X-rays _____
Address _____
Check if you have or have had problems with any of the following:

□ Bad Breath □ Grinding Teeth □ Sensitivity to Hot □ Bleeding Gums
□ Loose Teeth or broken Fillings □ Sensitivity to sweets □ Sensitivity when biting □ Clicking or pooping jaw
□ Periodontal Treatment □ Sensitivity to cold □ Food collecting between teeth □ Sores or growth in your mouth

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How often do you floss? _____ Hoe often do you brush? _____

MEDICAL HISTORY

Physician Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-pen"? These include combination of Iodine, Adipex, Fastin (brand names of phentermine), Padmini (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No
Have you ever had any serious illness or operations? □ Yes □ No If yes, describe_____
Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____
(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No
Check if you have or have had problems with any of the following:

☒ Anemia	■ Congenital Heart lesions	□ Hepatitis	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Cortisone Treatments	□ Hernia repair	□ Shortness of Breath
□ Artificial Heart Valves	□ Cough, persistent	□ High Blood Pressure	□ Skin Rash
□ Artificial Joints, Pins, Etc.	□ Cough up blood	□ HIV / Aids	□ Stroke
□ Asthma	□ Diabetes	□ Jaw Pain	□ Swelling of Feet or Ankles
□ Back Problems	□ Epilepsy	□ Kidney Disease	□ Thyroid Problems
□ Bleeding Abnormally	□ Fainting	□ Liver Disease	□ Tobacco Habit
□ Blood Disease	□ Glaucoma	□ Mitral Valve Prolapse	□ Tonsillitis
□ Cancer	□ Headaches	□ Pacemaker	□ Tuberculosis
□ Chemical Dependency	□ Heart Murmur	□ Radiation Treatment	□ Ulcer
□ Chemotherapy	□ Heart Problems	□ Respiratory Disease	□ Venereal Disease
□ Circulatory Problems	□ Hemophilia	□ Rheumatic fever	

List medications you are currently taking:

_____
_____
_____

ALLERGIES

□ Aspirin	□ Local Anesthesia	□ Iodine	□ Other
□ Barbiturates (sleeping pill)	□ Penicillin	□ Latex	_____
□ Codeine	□ Sulfa	□ None	

To the best of mu knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor, if I or my minor child, ever have had a change in health condition.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full, at the time of the treatment, unless prior arrangements have been approved.

General Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.
Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.
Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations, Preventive Services, Diagnosis, Basic Restorative, Periodontal Services, Crowns and/or Bridges, Prosthodontics, Implant Placements: Patient Initials: sdvsdv

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initials:** sdcsdv

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. **Patient Initials**: sdvsdv

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials**: sdvsdv

sdv	sdv	
Print Patient Name:	**Patient Signature**	**Date**

Monika Tyszkowski DDS Signature Date

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provide in detail the uses and disclosures on my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited or materially limited by law
- A description f other uses and disclosures that will be made only with written authorization and that I may revoke such authorization
- My individual rights with respect to protect health information and brief description of how I my exercise these right in relation to:
  - The right to complain to this practice to the Secretary of DHHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the of such a complaint
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction
  - The right to receive confidential communications of protected health information
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

I authorize Smiles of Lombard, PC to leave a message or send information regarding me personal health history, such as test results, physician/dentist messages, insurance or billing information or appointment information. **Please initial each line that you authorize**:

_____Telephone message _____Text message _____Email message
_____Mail to: □ Home ▣ Office Fax to: □ Home ■ Office Fax number: _____

This practice reserves the right to change the terms of this Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____ _____
Signature of Patient of Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)

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COMPOSITE FILLING

I understand the treatment of my dentition involving a placement of composite resign fillings which may be more aesthetic in appearance than some of conventional materials which have been traditionally used, such as silver amalgam or gold may entail certain risk. There is also possibility of failure to achieve then results which may be desired or expected. I agree to assume those risks which may occur even though care and diligence will be exercises by my treating dentist in rendering the treatment. This risk includes possible unsuccessful and/or failure which are associated with, but not limited to the following:

- Sensitivity of teeth: often after preparation of any restoration teeth may exhibit sensitivity. The sensitivity may last only for a short period of time or may last for much longer period of time. If such sensitivity is persistent or last for much extended period of time, I agree to notify the dentist in as much as this may be a sign of more serious problems.
- Risk of fracture: inherent in the placement of any restoration is the possibility of the creation of small fracture lines in tooth structure. Sometimes these fractures may not be apparent at the time of removal of tooth structure and/or the previous filling and placement or replacement, but ma manifest at a later time.
- Necessity of root canal treatment: when the filling are placed or replaced, the preparation of teeth for fillings often demands the removal of tooth structure adequate to insure that the diseases or otherwise compromise tooth structure provides sound tooth structure for placement of restoration. At times, this may lead to exposure of trauma to underlying pulp tissue, Should the pulp not heal, which often times is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.
- Injury in the nerves: there is a possibility of injury to the nerve of the lips, jaws, teeth, tongue, or other oral or facial tissues from and dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness which may occur is usually temporary, but in rare instances, could be permanent.
- Aesthetes or appearance: effort will be made t closely approximate the natural tooth color. However due to other fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the teeth coloration. Also, over a period of time, the composite filling, because of mouth fluid different food eaten, smoking, etc., may cause the shade to change. The dentist has no control over these factors.
- Breakage, dislodgement or bond failure: due to extreme masticatory pressure or other traumatic forces, it is possible for composite fillings to resin fillings or aesthesis restorations bonded with composite resin to be dislodged or fractured. The resin enamel bond any fill, resulting in leakage recurrent decay. The dentist has no control over these factors.
- New technology and health issues: composite resin technology continues to advance but some materials yield disappointing results over time and some fillings may have to be replaced by better improved materials. Some patients believe that having metal fillings replaced with composite fillings will improve their health. This notion has not been proven scientifically and there are no promises or guarantee that the removal of silver fillings and the subsequent replacement with composites fillings will improve, alleviate, or prevent any current of future health conditions.

I understand it is my responsibility to notify the office should any undue or unexpected problems occur or if I experience any problems relating to the treatment rendered or the services performed.
INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of composite fillings and have received answers to my satisfaction. I do voluntarily assume any and all possible risks of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired and/or any results from the treatment to be rendered to me. The fees for this service have been explained to me and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize Dr. Tyszkowski and all associates involved in rendering any services she deems necessary or advisable to treatment of any dental conditions, including the administration and/or prescribing of any anesthetic agents and/or medications.

_____	_____	_____
Patient's name (please print)	Patient's signature	Date

SMILES OF LOMBARD - FINANCIAL POLICY

We are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top quality care as cost effective as possible. To promote a long term mutually satisfying relationship, we would like to explain our office policy regarding payment options, insurances, appointments and fees.

PAYMENT OPTIONS: Payment for service is due at the time that services are rendered. When insurance applies, we will collect any deductible and/or estimated co-payment at the time of service. We accept cash, check, Visa, MasterCard and Discover. In addition, we offer financing through Care Credit for those requiring payment plans.

INSURANCE: We will gladly discuss your proposed treatment, answer any questions relating to your insurance and provide you with an ESTIMATE of what your insurance company will pay towards your treatment. Our office can make no guarantee of the actual payment by your insurance company. Filing of insurance claims is a courtesy we extend to our patients. You must realize; however, that your insurance is a contract between you, your employer and your insurance company. You are FULLY RESPONSIBLE for the charges for the treatment rendered.

Primary Insurance Information:

Primary Insurance Company: _____Subscriber: _____

Subscriber's DOB: _____Relationship: _____ID #: _____Group #: _____

Secondary Insurance Information:

Primary Insurance Company: _____Subscriber: _____

Subscriber's DOB: _____Relationship: _____ID #: _____Group #: _____

MISSED APPOINTMENTS: Appointments are made on a per appointment basis and this time is reserved exclusively for you. As a courtesy, we attempt to remind you of your appointment by calling you, sending emails and/or texts to those patients who have signed up for these options; however, it is ultimately the patient's responsibility to keep their scheduled appointments.

When you fail to notify us of your inability to keep your appointment, another patient in need of dentistry is unable to receive treatment. We require that you give us at least 24 hours' notice when you realize that you cannot keep your scheduled appointment. A fee of $50 will be charged for all missed and short notice (less than 24-hour notice) cancelled appointments. After hours, our office has a 24-hour answering service that allows you to speak directly to someone.

Your signature below acknowledges that you received this form and you fully understand all of our policies.

_____ _____

Patient/Guardian Signature Date Printed Name