REGISTRATION

(PLEASE PRINT)

SMILE SOLUTIONS DENTAL CENTER

411 West Walnut Street
Mt. Prospect, IL 60056
847 255 5550
Kana Yajima, D.D.S.

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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

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

MEDICAL HISTORY

Since the cause of periodontal disease is a combination of many factors and very complex, it is necessary to determine all possible causative factors. The success of the treatment depends upon this. Although many of these questions may seem to have nothing to do with your gum condition, they are all related to possible contributing influences, in addition to avoiding any unnecessary complications during treatment.

1) Do you presently have or have you ever been treated for any of the following? (PLEASE CHECK)	YES ✓	NO ✓
a. convulsions ひきつけ		
b. epilepsy てんかん		
c. frequent headaches 頻繁に起こる頭痛		
d. nervousness 神経質		
e. rheumatic fever リュウマチ熱		
f. heart murmur 心臓の不整音		
g. heart attack 狭心症		
h. mitral valve prolapse 心臓弁膜の異常		
i. other heart problem 他の心臓の異常		
j. high blood pressure 高血圧		
k. diabetes 糖尿病		
l. anemia or other blood disorders 貧血 又は他の血液の病気		
m. TB or other respiratory disease 結核 又は 他の呼吸器系の病気		
n. ulcer 潰瘍		
o. cancer 癌		
p. arthritis 関節炎		
q. hepatitis 肝炎		
r. HIV positive エイズ		
s. thyroid disease 甲状腺病		
t. alcoholism or drug addiction アルコール依存症、又は薬物の常用		
u. any other medical disorder (Explain) 他の病気の有無		
v. do you have a pacemaker for your heart ペースメーカー使用		
w. do you have a prosthetic heart valve? 人工心臓弁膜使用		
x. do you have any artificial joints? (i.e. hip) 人工関節使用		

2) Have you ever had any of the following? (PLEASE CHECK)	YES ✓	NO ✓
a. surgical operation 手術の有無		
b. any complications from the operation? (Explain) 手術による合併症		
c. excessive bleeding after cuts, bruises or tooth extraction. 切傷、打ち身、抜歯後血液が止まりにくい		
d. an allergic or adverse reaction to a drug. アレルギーの有無 (eg. anaesthetic, penicillin, aspirin, latex-rubber etc ? Explain) 薬、麻酔、ペニシリン、アスピリン、ラテックスゴム等		
3) Are you presently taking any medicine? Please List: 何か薬を服用している		
4) Do you take vitamins? If so please list. ビタミン剤の服用		
5) Do you smoke? If so how much? 喫煙の有無		
6) Are you presently under a physician's care? If so what condition? 医師の診察を受けている		
7) Women Only: 女性のみ記入		
a. Are you taking birth control pills? バースコントロールピルの服用		
b. Are you pregnant? 妊娠の有無		
c. Have you gone through menopause? 閉経（更年期）		

When was the last time you were examined by a physician? (Date) _____

Explain any Yes answers above. _____

_____

_____

PATIENT'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____

お知らせ

当歯科医院は、患者さんの口腔内の健康を第一に考えて診療を行っております。その治療方針や歯科医療システムにご理解頂き、下記の注意事項をお守りください。

1. 患者さんご自身の治療やメインテナンスを確実に行うために、ご本人の健康に関する情報は、多少に関わらず出来るだけ詳しくご記入下さい。
2. 治療費のお支払いは、治療の都度お済ませ下さい。
   お支払い方法は、現金、チェック、クレジットカード（VISA, MASTER, DISCOVER, AMEX）、デビッドカードを受け付けています。
3. 治療費の分割払いについては、お気軽にご相談下さい。

保険について

当医院では、患者さんの初診後に、ご本人の保険補償額の査定を行っていますが、保険会社、またはプランによって、ご本人負担額が異なります。患者さんの保険契約は、患者さんと保険会社との契約で、当院は契約に関係ありませんが、患者さんの立場に立って出来るだけお手伝い致します。
当院で行う保険の査定は、あくまでも見積もりで 100%の保障はありません。また、最終的な保険補償額の確定は保険会社が行い、当医院は一切責任を負いかねますので予めご了承下さい。
最終的な確認は、患者さんと保険会社との間で行って下さい。

保険プランについて

当医院は、PPO タイプの保険に加入しています。患者さんの予想負担額は治療の都度お支払い下さい。年一回の初診料は初診時にお支払い下さい。尚、支払期限を過ぎた金額に対しては、延滞料金が加算されます。

海外旅行保険について（自由保険）

治療費のお支払いは、治療の都度お済ませ下さい。

治療価格について

歯科治療価格は、地域、プラン等によって異なります。当医院の治療価格は一般的な価格となっています。

未成年の患者さんについて

未成年の患者さんの治療は、ご両親または、保護者にお支払い頂きます。

予約の変更、キャンセルについて

予約の変更、キャンセルは、緊急時を除き遅くとも 24 時間前まで当医院に連絡がない場合は、キャンセル料をお支払い頂きます。

当医院の診療の注意事項にご理解頂きまして有難うございます。
何かご質問がありましたらお気軽にお問い合わせ下さい。

スマイルソリューションズ　矢島歯科

私は、上記に理解し、ここに同意します。

日付＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

氏名＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

How Can We Reach You?

Your dentist and other staff members will at times need to contact you. By filling out the information below, we will be better able to serve you.

Name of Patient _____ Date of Birth _____

Home / Evening Phone # _____
Work / Daytime Phone # _____
Cell / Other Phone # _____

Smile Solutions Dental Center; In order to protect your privacy, we have developed a policy on leaving or discussing any kind of medical information.

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave any information on an answer machine.
- We will NOT leave any messages on a voice mail.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO
Please read below and carefully consider whom you want to have access to your medical / dental information.

I, _____give Smile Solutions Dental Center my permission to leave a phone message regarding my medical/dental care, account information, appointment reminder or discuss my medical / dental issues with the following. I fully understand that this consent will remain until revoked in writing.

My home answering machine / voice mail _____Initials

My Cell phone mail _____Initials

My Office / work voice mail _____Initials

My Spouse / significant other (name) _____ _____Initials

My Family Members _____ _____ Initials

Emergency contact/phone number_____ _____Initials

Relationship_____ _____Initials

I acknowledge I completed this form and have received a copy of the Smile Solutions Dental Center's Notice of Privacy Practices.

_____ _____
SIGNATURE DATE

SMILE SOLUTIONS DENTAL CENTER
Cosmetic, Periodontics, Implant & General Dentistry
411 West Walnut Street • Mt. Prospect, IL 60056
847.255.5550 • Fax: 847.259.3945

ACKNOWLEDGEMENT OF RECEIPT OF 'NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign this Acknowledgement"

I _____ have received a copy of this offices Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the a acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)