ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? _____ What was done at that appointment? _____

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____	☐	☐	☐
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____	☐	☐	☐
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____	☐	☐	☐
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____	☐	☐	☐
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

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PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: _____ Phone: _____

Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**	
Is the patient currently being treated for any condition(s) or illness(es)?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?	☐	☐	☐	If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized?	☐	☐	☐	When and why?
Has the patient ever been given a general anesthetic?	☐	☐	☐	
Has the patient ever had a blood transfusion?	☐	☐	☐	
Does the patient experience excessive bleeding when cut?	☐	☐	☐	
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist?	☐	☐	☐	If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any genetic (inherited) conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any speech difficulties?	☐	☐	☐	If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- ☐ ADD/ADHD
- ☐ Alcohol/Drugs
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Bleeding disorders
- ☐ Bone/Joint issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic sinusitis
- ☐ Diabetes
- ☐ Ear aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth problems
- ☐ Hearing problems
- ☐ Heart Issue
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Immunizations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually transmitted infection (STI)
- ☐ Sickle Cell Anemia
- ☐ Thyroid issues
- ☐ Tobacco/Vaping
- ☐ Tuberculosis
- ☐ Other: _____

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**
Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?	☐	☐	☐
If yes, please list them here: _____			
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?	☐	☐	☐
If yes, please list those medications and what happened when the patient took them: _____			
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.?	☐	☐	☐
If yes, please describe the allergy and the reaction: _____			

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only:

☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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ROBERT T. SVEN, D.D.S., LTD.
A General Family Dental Practice
Antioch Dental Center
439 Lake Street
Antioch, IL. 60002

For Appointments Call
(847) 395-3250

Insurance and Billing
(847) 395-3493

PAYMENT POLICY

Dear Patient:

We at Robert T. Sven, D.D.S., LTD. Are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental services available today. In order to assist you with this investment we are providing the following options from which you can select a plan that best meets your financial needs.

- **Cash:** Including money orders and personal checks.
- **Credit Cards:** Visa, Master Card, Discover and American Express

Insurance: We understand the value of insurance benefits and will assist you in obtaining your maximum benefits. Due to the many variables in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay abreast of the insurance industry, it is not always possible. Therefore, we encourage you, the patient to please check with your insurance company about your individual benefits. It is your responsibility to know your individual coverage. Please remember, dental insurance policies are between the patient and the insurance company; not the insurance company and the doctor.

We will process your insurance claim for you and estimate your deductible and the portion that is not covered by insurance. That **amount is due at the time of treatment** and may be paid by any of the options listed above. Our estimates are in no way a substitute for your insurance company's final say and could, therefore, change your amount due our office.

We will be happy to work with you to plan the most appropriate arrangements for your budget. Failure to comply with the above mentioned will result in your account being sent to a collection agency. Besides being responsible for the account balance, you will also be responsible for all fees associated with the collection of your balance.

Sincerely,

Robert T. Sven, D.D.S., LTD.

I agree to pay for my dental services as outlined in the payment policy above.

_____ _____

Print Patient Name | Date

_____ _____

Signature of Patient or Guardian | Relationship to Patient

Robert T. Sven, D.D.S., LTD.
Antioch Dental Center
439 Lake Street
Antioch, IL 60002

847-395-3250

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices from

Robert T. Sven, D.D.S., LTD, Antioch Dental Center.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ OTHER:

Robert T. Sven D.D.S., LTD.

Antioch Dental Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/07/02, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Cissy Nelson

Telephone: 847/395-3261 Fax: 847/395-4045

E-mail: RTSvenDDS@aol.com

Address: 439 Lake Street, Antioch, IL, 60002-1472

ROBERT T. SVEN, D.D.S., LTD.
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Antioch, IL 60002
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Robert T. Sven, D.D.S.
President

To: Our Patients
From: Dr. Robert T. Sven

Considering the ongoing concerns involving disease transmission, I feel it is important to let you know how unique our office is and, especially, how committed we are to our Infection Control Program.

In order to continue to offer you maximum protection, my staff and I have been trained in the latest techniques on Infection Control. All instruments and handpieces are heat sterilized, and our autoclaves are routinely tested to insure that sterility is maintained.

Our sterilization procedures are reevaluated on a routine basis to guarantee that we meet, if not exceed, the most current Government Regulations. In addition, we provide each of our patients with their own individually wrapped, sterile instrument pack and protective covers.

These procedures, while essential to delivering high quality dental care, have dramatically increased the cost of providing dental services. While the process of increasing fees might be the most simple solution, it may not be he most fair to you. It could cause your "per visit fee" to increase disproportionately, depending upon the number of procedures performed at each visit.

In order to continue to offer you maximum protection without implementing a drastic, and perhaps unfair increase in our current fees, a modest charge of $7.00 per visit for Prophylaxis (cleanings), and $10.00 per visit for operatory treatment such as : Operative (fillings), Crown and Bridge, Extractions, Root Canals and Oral Surgery will be in effect. While dental insurance companies may acknowledge this fee, they may not elect reimbursement at this time. We suggest that you ask your employer to request that this essential procedure for protection be covered in your plan.

We are proud to continue to offer you the highest quality care, combined with maximum protection. At your next visit, please ask us to show you the types of sterilization procedures we regularly provide for all our patients. We appreciate the confidence you have placed in us, and we will continue to care for your health and safety as we serve your dental needs.

Best wishes for your continued good health.

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Robert T. Sven, D.D.S.
President

NEW TECHNOLOGY

To: Our Patients

From: Dr. Robert T. Sven

We are using an Argon Laser to bond and harden composite (white) fillings to the tooth. The Argon Laser helps us to produce a superior filling.

We have now started to use another laser that is called the Continuum. It has recently been approved by the FDA for the removal of decay on hard tissue, and we are the first in our state to have this technology. There is no loud drilling, no vibration and, in most cases, no anesthetic or shot needed with this laser. This is due to the mechanics of the way the laser removes hard tissue of enamel, resulting in a more comfortable procedure. Because of this the laser works best on small, new cavities. In order to receive the most benefit from this new technology, it is very important to have frequent maintenance visits so that cavities are detected early.

The Continuum Laser will not completely replace the drill. At this time, access to all teeth is limited and removal of silver fillings will need the aid of the conventional drill. However, as technology progresses, so will the use of lasers in our practice.

A third laser has been implemented called the Diode. This laser is used on the soft tissue of the mouth. The Diode eliminates the need of a scalpel which makes procedures more comfortable. We have been informed by many of our patients that with the Diode Laser the healing process has been virtually pain-free.

Other benefits offered includes Computed Dental Radiography (CDR). CDR reduces radiation exposure by ninety percent. This method is also environmentally friendly because it eliminates the chemicals required to develop the x-ray and preserves the life of the x-ray reducing the risk of fading.

Please be assured that performing dentistry in the most comfortable way available for the patient will continue to be my priority.