Welcome To

Dr Madhavi Gadde
4118 N Cass Ave, Westmont, IL 60559

About Patient

Patient Name: Last _____
First _____ MI _____
Status: Single _ Married _ Divorced _ Widowed _
Male __ Female __ Birthdate __/__/____ Age: ____
SS# _____ Best Phone #: (____)_____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____
How did you hear about us? _____
Referred By: _____

Is Patient Employed? Y N
Name of Employer: _____
Phone of Employer: __(____)_____
Occupation: _____

(If Married)
Spouses Name: _____
Birthdate of Spouse: ___/___/_____
Phone Number: (____)_____

In Case of Emergency (Whom do we contact)
Name: _____
Relationship to Patient: _____
Best Phone #: (____)_____

Insurance Info

Insured Name: Last _____
First: _____
Birthdate: ___/___/_____
Male __ Female __
Relationship to Patient: _____
Insured ID # Or SS#: _____

Insured Employer: _____
Insurance Name: _____
Phone #: (____)_____

Secondary Dental Insurance: Y N

Insured Name: Last _____
First: _____
Birthdate: ___/___/_____
Male __ Female __
Relationship to Patient: _____
Insured ID # Or SS#: _____

Insured Employer: _____
Insurance Name: _____
Phone #: (____)_____

Account Info Person Ultimately Responsible For Account

Name of Person Responsible for Account: Last _____ First: _____
Birthdate: ____/____/_____ Relationship to Patient: _____ SS#: _____
Billing Address: _____ City: _____ State _____ Zip: _____
Best Phone #: ___(____)_____ Drivers License #: _____

Payment Method: Cash ___ Checks ___ Credit Card ___
(If using Credit Card) Type: Visa __ American Exp __ Discover __ Mastercard __
Number to keep on file: _____
Name on Card: _____ Exp Date: __/__/_____
3 Digit Code: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (Smiles of Westmont / Dr Madhavi Gadde). I fully understand I am solely responsible for any balance not paid by my insurance company. I authorize the provider to release any information required to insurance company to process insurance claims.

Signature of Patient or Guardian: _____
Date: ___/___/_____

Dental Information

Reason for today's visit: Complete Exam / Cleaning ___ Emergency ___ Second Opinion ___
Are you currently in pain: Y N How long ? _____ Where is the discomfort? _____
Do you have any of the following: Check all that apply to you
Discomfort, clicking or popping jaw ____ Lost/ Broken fillings ___ Stained teeth ___ Broken/ chipped tooth ___ Teeth grinding ___
Blisters/ Sores in or around the mouth ___ Locking jaw ___ Sensitive tooth, teeth or gums ___ Red, swollen or bleeding gums ___
Ringing in ears ___ Bad breath ___ Decay/ Cavities ___ Broken Crowns/ Bridges ___
Do you wear any removable appliance(s) in mouth ___ If so do they fit properly: Y N How old are the appliances: _____
Other issue not listed? _____
Do you Require Pre-Medication? Y N Have you ever been treated for gum disease? Y N
Last Dental Exam: ___/___/___ Last Dental X-rays:___/___/___ Last Dental Cleaning: ___/___/___
How many times a day to you brush? ____ Floss? ____ Would you like whiter teeth? Y N Rate your smile 1-10: ____
Have you had Orthodontic Treatment (Braces)? Y N If so do you wear Retainers? Y N
What would you change about your smile? _____
Do you have Sleep Apnea(Stop Breathing while sleeping)? Y N Problems Sleeping? Y N Snoring? Y N
Would you be interested in a device that helps with sleep issues? Y N

Information Of Patient's Medical History (Please check all that apply to patient)

Heart Murmur ___ Heart Attack/Stroke ___ Heart Surg/Pacemaker ___ Heart Disease/Angina ___ Shingles ___ Lung Disease ___
Thyroid Problems ___ Congenital Heart Defect ___ Cancer/Tumors/Growths ___ Chemotherapy/Radiation ___ X-ray/Cobalt Treatment ___
Leukemia ___ Hepatitis ___ Liver Problems ___ Seizures/Epilepsy ___ Artificial Heart Valves ___ Artificial Bones/Joints/Implants ___
Blood Disease ___ Mitral Valve Prolapse ___ Bleeding Problems/Anemia ___ High/Low Blood Pressure ___ Bruise Easily ___ Scarlet Fever ___
Kidney Problems ___ Frequent Thirst Urination ___ Tuberculosis TB ___ Emphysema/Asthma ___ Dizziness/Fainting ___ Rheumatic Fever ___
Blood Transfusion ___ Diabetes/Hypoglycemia ___ Respiratory Problems ___ HIV+/AIDS/ARC ___ Severe/Frequent Headaches ___ Glaucoma ___
Arthritis/Gout ___ Chest Pains ___ Nervousness ___ Jaw Problems TMJ/TMD ___ GI Problems/Ulcers ___ Eating Disorder ___
Alcohol/Drug Abuse ___ Sinus Problems ___ Psychiatric Problems ___ Back/Neck Problems ___ Venereal Disease ___ Cosmetic Surgery ___
Cold/Fever Blisters ___ Blood Thinners ___ Taking Aspirin ___
Please list any surgeries or other medical conditions patient has ever had:

_____

_____

Medications Patient is on:

_____

_____

Allergies? Latex ___ Penicillin/Amoxicillin ___ Tetracycline ___ Aspirin ___ Codeine ___ Anesthetics ___
Others: _____ Food Allergies? _____
Does Patient use Tobacco: Y N If yes: How Much _____ How Long _____
Do You Wear Contact Lenses: Y N
(Women): Are you taking Birth Control Pills? Y N Are you taking Hormonal Replacements: Y N
Pregnant: Y N if yes, how far along? _____ Are you currently nursing? Y N

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office/ Dr. of any changes to the information I have provided.

The Office Policy requires payment for services rendered at the time of visit, unless other arrangements have been made. If I do not pay delinquent account over 90 days, I understand that my account will go into collection, and I will be responsible for any collection agency fees, interest charges and or other expenses incurred in collecting my account.

I authorize the staff to perform any necessary services needed during diagnosis and treatments. I also authorize the office Smiles of Westmont/ Provider Dr Madhavi Gadde to release any information required to process insurance claims or Lab Procedures.

Signature Patient or Guardian: _____
Date: ____/_____/_____
(Office Use:) Updates to History form
Initials _____ Date _____ Comments _____ Initials _____ Date _____ Comments _____
Initials _____ Date _____ Comments _____ Initials _____ Date _____ Comments _____

Smiles of Westmont/ Dr Madhavi Gadde
4118 N Cass Ave Westmont, IL 60559
630-852-4848

HIPAA Form

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

For Treatment we may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, assistants, technicians/labs, or other personnel, including people outside our office, who are involved in your sleep care and need the information to provide you with the proper care. I can obtain a copy of the HIPAA Notice Of Privacy Practices if I so do request. I understand that I can refuse to Sign This Acknowledgement

Authorization to Release Information

This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I,_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself or children.

_____ Print name of person and relationship

_____ Print name of person and relationship

I, _____, give, Smiles of Westmont, permission to leave messages on my answering machine/cell phone or with other family members in my household of confirmation of my appointments or missed appointments or to let me know of any treatments that I may require when I am not available to speak with. I give permission to Smiles of Westmont to release information required to insurance companies/third party billings to secure the payment of benefits.

Family members who are in my household where as this HIPAA form will also cover

_____

_____

_____

_____

Print Name of Patient _____

Signature of Responsible Party _____

Relationship: Self Parent Guardian

Date ____/____/_____