North Michigan Avenue Dental Group
Dr. Sanya Kirovski
Dr. Maryann Kelly

845 N Michigan Avenue Suite 953W, Chicago, IL 60614

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. As required by law, our office adheres to written policies and procedures to protect the privacy of information. This office does not use this information to discriminate. All information will be kept strictly confidential. *Thank You.*

Name_____ Preferred Name_____
Last First

Salutation: ☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr.

☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

☐Male ☐Female Social Security No._____ Birthdate_____

Mailing Address_____ City_____ State_____ Zip_____

Email_____

Cell Phone_____ Home Phone _____ Preferred phone for contact ☐Cell ☐Home

Whom may we thank for referring you?_____

Patient Occupation_____ Employer_____ Work Phone_____

Name of Spouse_____ Birthdate_____ Social Security No._____

Spouse Occupation Employer_____ Work Phone_____

Do you have a preferred pharmacy?

Name_____ Phone_____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employer_____	Employee_____
Employer_____	Employee_____
Insurance Co._____ Group#_____	Insurance Co._____ Group #_____
Employee's SS No._____	Employee's SS No._____

Person responsible for payment:_____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name_____ Home Ph. No. _____ Relationship to Patient_____

Medical History

Name_____

Physician_____Location/Phone_____

Have you ever had any of the following diseases or medical problems? Please select Y (yes) N (no)

☐Y ☐N Angina Pectoris
☐Y ☐N Prosthetic Heart Valves/Stents
☐Y ☐N History of Infective Endocarditis
☐Y ☐N Cancer If yes, date range_____
Chemotherapy date range_____
Radiation date range_____
☐Y ☐N Congenital Heart Defect
☐Y ☐N Cardiac Transplant
☐Y ☐N C. Difficile
☐Y ☐N Stroke/TIA If yes, when_____
☐Y ☐N Arrhythmia
☐Y ☐N Pacemaker
☐Y ☐N High/Low Blood Pressure
☐Y ☐N Diabetes
☐Y ☐N Asthma/Respiratory
☐Y ☐N Tuberculosis
☐Y ☐N Stomach Ulcers
☐Y ☐N Thyroid Disorder
☐Y ☐N Blood Transfusion
☐Y ☐N Abnormal Bleeding/Sickle Cell/Hemophilia
☐Y ☐N Have you been hospitalized in the past two years?

☐Y ☐N Prolonged bleeding/Anticoagulants
☐Y ☐N Liver Disease
☐Y ☐N Hepatitis A, B, C
☐Y ☐N HIV/AIDS
☐Y ☐N Kidney Failure/Dysfunction
☐Y ☐N Epilepsy/Seizure/Fainting Spells
☐Y ☐N Artificial Hip/Knee Joints If yes, when_____
☐Y ☐N Does your orthopedic doctor recommend antibiotic prophylaxis?_____
☐Y ☐N Autoimmune Disorders/Lupus
☐Y ☐N Psychiatric Treatment/Depression
☐Y ☐N Sinus Problems
☐Y ☐N Severe or Frequent Headaches/Migraines
☐Y ☐N Sleep Apnea
☐Y ☐N Recent Surgery_____
☐Y ☐N Drug/Alcohol Addiction
☐Y ☐N Tobacco Use If yes, how many pack/day?_____
Other conditions not indicated:
_____
Reason_____
Women: Are you pregnant? ☐Y ☐N

Are you currently taking:
☐ Actonel ☐ Boniva ☐ Zometa ☐ Areolia ☐ Fosamax ☐ Reclast

Do you take medications, vitamins, herbs, over-the-counter medication? ☐Y ☐N If yes, please list_____
_____

Do you have any allergy to the following?

☐Y ☐N Asprin
☐Y ☐N Codeine
☐Y ☐N Sulfa
☐Y ☐N Dental Anesthetic
☐Y ☐N Erythromycin
☐Y ☐N Tetracycline
☐Y ☐N Other Antibiotics
☐Y ☐N Latex
☐Y ☐N Metals/Jewelry
☐Y ☐N Sedatives
☐Y ☐N Anti-inflammatory Medication
☐Y ☐N Penicillin

Are you aware of any other drugs that you are allergic to? If yes, please indicate_____

Dental History

Reason for the visit?_____
When was your last dental visit?_____
Previous Dentist name?_____
☐Y ☐N Have you had a complete series of dental films?
How often do you brush your teeth?_____
How often do you floss your teeth?_____
☐Y ☐N Do your gums bleed?
☐Y ☐N Are your teeth sensitive to hot or cold?
☐Y ☐N Do you have difficulty chewing?
☐Y ☐N Do you have any pain or discomfort?
☐Y ☐N Have you ever had any head, or jaw injuries?
☐Y ☐N Do you have frequent headaches?
☐Y ☐N Do your teeth ever feel loose?

☐Y ☐N Have you ever had periodontal treatment?
☐Y ☐N Have you ever worn bite plate or other appliance?
☐Y ☐N Do you have dry mouth?
☐Y ☐N Are you happy with the way your smile looks?
If not, what would you change?_____
_____
☐Y ☐N Are you apprehensive about dental work?
If yes, reason?_____
☐Y ☐N Are your teeth sensitive to sweet or sour?
☐Y ☐N Do you have any sores in or near your mouth?
☐Y ☐N Do your jaw joints make any noise?
☐Y ☐N Do you grind your teeth?
☐Y ☐N Does your food catch between your teeth?

I understand that the information I have given today is correct, to the best of my knowledge.

Patient Signature_____***Date***_____

North Michigan Avenue Dental Group
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Dr. Maryann Kelly

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https://www.bestcosmeticdentistchicagoil.com

OFFICE FINANCIAL POLICY

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these payment options for payment.

- Visa or Master Card
- Check
- Individualized Monthly Payment Plan

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solutions possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other prior arrangements have been made.

I understand that any estimated portion, not covered by insurance, is due at the time of service for all services regardless of whether or not my insurance benefits have been received. One percent (1%) monthly interest, twelve percent (12%) per year (per RCW 19.52) will be charged on accounts 60 days from the treatment date. I also understand that should credit be extended to me by this dental office, I authorize release of all financial data.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience. Thank you for giving us the opportunity to car for your dental needs.

Patient Signature_____***Date***_____

Chart #:_____
FOR OFFICE USE ONLY

Patient Name:_____Date:_____
Last First MI (Preferred Name)

E-Mail Address:_____Family Status:_____

Consent for Internet Communications

I grant my permission to Sanya Kirovski D.D.S. to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Sanya Kirovski D.D.S.. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Sanya Kirovski D.D.S. and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Sanya Kirovski D.D.S. is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Sanya Kirovski D.D.S. is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Sanya Kirovski D.D.S. web site with my ID and password. I also agree to immediately notify Sanya Kirovski D.D.S. of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Sanya Kirovski D.D.S. will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Sanya Kirovski D.D.S. has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Sanya Kirovski D.D.S. will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Sanya Kirovski D.D.S. CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Sanya Kirovski D.D.S., and grant Sanya Kirovski D.D.S. permission to securely upload my patient information to the web site.

_____Date: _____Relationship to Patient:_____
Signature of patient, parent or guardian

NORTH MICHIGAN AVENUE DENTAL GROUP
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info@nmadental.com

NOTICE OF PRIVACY PRACTICES AGREEMENT

1. I hereby authorize the doctor or the designated staff members to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

2. Upon such diagnosis: I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embody certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff members use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I have read and understand the **Notice of Privacy Practices** available on our website.

I assign to Dr. Kirovski/Dr. Kelly all insurance benefits otherwise payable to me for services rendered. I understand that I am responsible for charges paid or unpaid by insurance. I authorize the use of my signature for all claim submissions. The above named dentist is authorized to disclose my healthcare information to the above named Insurance Company for the purpose of obtaining payment and determining benefits.

Patient's Signature_____Date_____

Parent/Responsible
Party Signature_____Relationship_____