SMILES ON ELSTON

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____ Nickname_____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ ❑ Male ❑ Female SS#_____

Address _____ City_____ State _____ Zip _____

Employer_____

State ID/Driver's License # _____ Email Address _____

Name of Physician_____ Physician Phone_____

Emergency Contact: _____ Relationship_____Phone _____

How did you hear about our office?_____

PATIENT HEALTH HISTORY

Do YOU have a history of:

AIDS/HIV Positive . . . . . ❑
Alcoholism . . . . . ❑
Allergies . . . . . ❑
Anemia . . . . . ❑
Arthritis . . . . . ❑
Asthma . . . . . ❑
Blood Disease . . . . . ❑
Stomach Ulcers . . . . . ❑
Stroke . . . . . ❑
Thyroid Disease . . . . . ❑
Tuberculosis . . . . . ❑
Tumors or Growths . . . . . ❑
Ulcers . . . . . ❑
Venereal Disease . . . . . ❑
(Sexually Transmitted Disease)

Excessive Bleeding . . . . . ❑
Epilepsy . . . . . ❑
Glaucoma . . . . . ❑
Hay Fever . . . . . ❑
Head Injuries . . . . . ❑
Hearing Impaired . . . . . ❑
Heart Disease . . . . . ❑
Bone Disease . . . . . ❑
Cancer . . . . . ❑
Chemical Dependency . . ❑
Chest Pain . . . . . ❑
Circulatory Problems . . . ❑
Convulsions/Seizures . . . ❑
Diabetes . . . . . ❑

Jaundice . . . . . ❑
Kidney Disease . . . . . ❑
Kidney dialysis . . . . . ❑
Latex Sensitivity . . . . . ❑
Lupus . . . . . ❑
Low Blood Pressure . . . . ❑
Malignancies . . . . . ❑
Heart Valve, Murmur . . . ❑
Hepatitis/Liver Disease . ❑
*Type(s)*_____
Hepatitis Carrier . . . . . ❑
High Blood Pressure . . . . ❑
Hip/Joint Replacement . . ❑
HPV . . . . . ❑

Respiratory Problems . . . ❑
Rheumatic Fever . . . . . ❑
Rheumatism . . . . . ❑
Scarlet Fever . . . . . ❑
Seizures/Fainting Spells . . ❑
Sinus Problems . . . . . ❑
Sleep Apnea . . . . . ❑
Mitral Valve Prolapse . . . . ❑
Neck & Back Problems . . . ❑
Nervous Problems . . . . . ❑
Pacemaker . . . . . ❑
Prosthetic Joints . . . . . ❑
Psychiatric Care . . . . . ❑
Radiation Treatment . . . . ❑

MEDICAL QUESTIONS

Are you allergic to any medications? . . . . . ❑ Yes ❑ No

If yes, please list:_____

_____

List any medications you are taking, including nonprescription drugs: _____

_____

Are you in good health? . . . . . ❑ Yes ❑ No

Date of last medical exam?_____

Have you ever been hospitalized? . . . . . ❑ Yes ❑ No

If yes, what was the reason?_____

_____

_____

Do you have any disease/problem you think we should know about? . . . . . ❑ Yes ❑ No

If yes, please explain: _____

_____

Have you had a transplant operation that has depressed your immune system? . . . . . ❑ Yes ❑ No

Have you had an allergic reaction to bananas? . . ❑ Yes ❑ No

Do you smoke or chew tobacco? . . . . . ❑ Yes ❑ No

Have you had heart surgery? . . . . . ❑ Yes ❑ No

Are you now under the care of a physician? . . . ❑ Yes ❑ No

Are you taking or have ever taken bisphosphonates? *(Fosamax or Actonel for osteoporosis, chemotherapy, etc)* . . . . . ❑ Yes ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? . . . . . ❑ Yes ❑ No

Are you pregnant? . . . . . ❑ Yes ❑ No

Expected delivery Date: _____

Are you nursing/breastfeeding? . . . . . ❑ Yes ❑ No

Is there a possibility of pregnancy? . . . . . ❑ Yes ❑ No

NOTE: *Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*

DENTAL HISTORY INFORMATION

Reason for today's visit? _____

_____

_____

Date of last dental visit? _____

Name of your previous dentist _____

_____

Have you ever had an oral cancer screening? . . . . ❑ Yes ❑ No

Do your gums bleed when you brush? . . . . . ❑ Yes ❑ No

Have you or a family member even been treated for periodontal disease? . . . . . ❑ Yes ❑ No

Have you ever had complications from an extraction?. . . . . ❑ Yes ❑ No

Have you ever had a popping or clicking near your ear when you chew? . . . . . ❑ Yes ❑ No

Are you prone to frequent headaches?. . . . . ❑ Yes ❑ No

Do you grind or clench your teeth? . . . . . ❑ Yes ❑ No

Do you have sores, blisters, or swelling on your gums, lips, or cheeks?. . . . . ❑ Yes ❑ No

Have you ever had orthodontic treatment? . . . . . ❑ Yes ❑ No

Do you snore?. . . . . ❑ Yes ❑ No

Do you have problems with bad breath? . . . . . ❑ Yes ❑ No

Have you ever used an electric toothbrush? . . . . . ❑ Yes ❑ No

Are your teeth sensitive to hot, cold, or pressure? . . . . . ❑ Yes ❑ No

On a scale from 1 to 5, with 5 being the highest, how happy are you with your smile/oral health?

1 2 3 4 5

If you could change something about your smile, what would it be?

- ❑ Whiter
- ❑ Straighter
- ❑ Close space(s)
- ❑ Replace silver/black mercury filling with tooth colored restorations
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Less gums showing
- ❑ Replace old crowns or caps that don't match
- ❑ Other _____

_____

_____

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: *I hereby consent to the treatment indicated on my examination form, including the use of any anaesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.*

*Patient*_____ *Date*_____

*Parent/Guardian*_____ *Date*_____

*Doctor's Signature*_____ *Date*_____

SMILES ON ELSTON

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 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 December 7, 2012, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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. We will post a copy of our notice in our office and on our website www.smilesonelston.com. The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

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

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and 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 fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, Smiles on Elston, 5780 N. Elston Ave., Chicago, IL 60646.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, Smiles on Elston, 5780 N. Elston Ave., Chicago, IL 60646. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, Smiles on Elston, 5780 N. Elston Ave., Chicago, IL 60646.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, Smiles on Elston, 5780 N. Elston Ave., Chicago, IL 60646. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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.

PRIVACY OFFICER Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
Smiles on Elston
5780 N. Elston Ave.
Chicago, IL 60646
Telephone: (773) 763-7434

SMILES ON ELSTON

ACKNOWLEDGEMENT OF RECEIPT OF *SMILES ON ELSTON* NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, _____, have received a copy of the Smiles on Elston Notice of Privacy Practices.

Signature _____ Date _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____ Relationship to Patient _____

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 acknowledgement

❑ An emergency situation prevented us from obtaining acknowledgement

❑ Other (Please Specify)_____

_____

_____

SMILES ON ELSTON

PAYMENT ARRANGEMENT FORM

PATIENT NAME ("patient")

PAYMENT AGREEMENT I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to *Smiles on Elston* at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while *Smiles on Elston* will file claims with my insurance company on my behalf, I remain responsible to *Smiles on Elston* for what is not paid by my insurance company. I also understand that if *Smiles on Elston* cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that *Smiles on Elston* may charge:

1) a late fee if payment on my account is not received by the due date;

2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and

3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice.

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to *Smiles on Elston*.

RESPONSIBLE PARTY:

Full Name _____ DOB _____ SS# _____

Street Address_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer Name _____

INSURANCE INFORMATION:

PRIMARY INSURANCE:

Primary Insurance Name _____ Address_____ Phone Number_____

Name of Insured _____ Relationship _____ID Number_____ Group Number_____

SECONDARY INSURANCE:

Secondary Insurance Name _____ Address_____ Phone Number_____

Name of Insured _____ Relationship _____ID Number_____ Group Number_____

I acknowledge having received a copy of Smiles on Elston's Notice of Privacy Practices. *I agree that a photocopy of this authorization is as valid as the original.*

Location where this agreement was signed: Smiles on Elston, 5780 N. Elston Ave., Chicago, IL 60646

*Signature of Responsible Party*_____ *Date* _____

(to be signed even if Patient is also the Responsible Party)