

PATIENT REGISTRATION AND MEDICAL HISTORY

Date: _____

Home Phone: _____

Patient: _____
Last Name First Name Middle Initial Preferred Name

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Cell Phone: _____

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

Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone: _____

Spouse/Parent Name: _____ Spouse/Parent Birthdate: _____

Spouse/Parent Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security#: _____ Spouse/Parent's Social Security#: _____

Name of Dental Insurance Company: _____ Group Number: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (check boxes that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Venereal Disease |

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? Yes No

Are you taking any medication at this time? _____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) Yes No

Are you under the care of a physician? Yes No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? Yes No Due date: _____

Are you nursing? Yes No Taking birth control pills? Yes No

Is there anything else we should know about your medical history? _____

DENTAL TREATMENT CONSENT FORM

Patient Name: _____

Birthdate: _____

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions' _____
Impacted teeth removed _____ General Anesthesia _____ Root Canals _____ Other _____

(Initials. _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials. _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials. _____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that may last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization complications arise during or following treatment, the cost of which is my responsibility.

(Initials. _____)

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initials. _____)

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials. _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasional metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand the occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials. _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or my mine child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

(Initials. _____)

(NAME OF PRACTICE)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____: have received a copy of the office's Notice of
Privacy Practices.

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
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify)

(NAME OF PRACTICE)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DECLARES 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 notice while it is in effect. This notice takes effect will remain in effect until we replace it.

We reserve the right change our privacy practices and the term 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 term of our notice effective for all health information that we maintain including health information we created and received before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make new notice available upon request.

You may requested a copy of our notice at any time. For more information about our privacy practices, or additional copies of notices, please contact us using the listed 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 examples

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 OPERATION: 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. My 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 heath 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 reason able 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 dis close your health information to the extent necessary to avert a serious threat to your neath or safety of the rear 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 the 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. _____ for each page. \$ _____ 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.

RESTRICTIONS: 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 complaints to 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: West Chicago Dental Center

Telephone: (630) 562-8700

E-mail: office@westchicagodentalcener.com

Address: 440 E. Roosevelt Rd. Suite 112, West Chicago, IL 60185