WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

① Patient Information

Today's Date: _____

Name: _____

Referred By: _____

❒ Male ❒ Female Birthdate: ___/___/___ Age: ___

SS#: _____

Home Address: _____

_____ Zip _____

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Hm #: (____)_____ Pager/Cell: _____

Wk.#: (____)_____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

_____ Zip _____

Occupation: _____

Where & when are the best times to reach you? _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

② Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's SS #: _____

Insured's Employer: _____

③ Spouse Information

His/Her Name: _____

Employer: _____

Wk.#: (____)_____ Ext: _____ SS#: _____

Birthdate: ___/___/___ DL#: _____

Person Responsible for Account: _____

Wk.#: (___)_____ Ext: ___ Hm#: _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL#: _____

④ Medical History

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name: _____

Phone #: (_ _)_____ **Last Visit Date:** _____

Are you currently under the care of a physician? ❒ Yes ❒ No

Please Explain: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk.#: (___)_____ Hm#: (___)_____

⑤ Medical History

Your current physical health is:
❒ Good ❒ Fair ❒ Poor

Do you use or smoke tobacco in any form? ❒ Yes ❒ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ❒ Yes ❒ No

Please list each one: _____

_____

Have you ever taken Phen-Fen? ❒ Yes ❒ No

(Also known as Redux or Pondimin) if yes, when? _____

For Women: Are you taking birth control pills?
❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No Week #: _____

Are you nursing? ❒ Yes ❒ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Use
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints /Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any medical conditions that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Jewelry/Metals Y N Tetracycline
Y N Dental Anesthetics Y N Latex Y N Other

Please list ant other drugs/materials that you are allergic to:

_____

_____

⑥ Dental History

Why have you come to the dentist today?

Has your doctor told you that you require antibiotics before dental treatment? ❒ Yes ❒ No

Are you currently in pain? ❒ Yes ❒ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you of have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Do you like your smile? ❒ Yes ❒ No

Do your gums ever bleed? ❒ Yes ❒ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ❒ Hard ❒ Medium ❒ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changed in my medical status I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us.

We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA>

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____ Date: _____

Doctor's Comments: _____

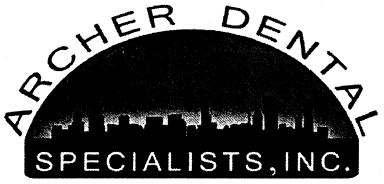
_____

MEDICAL HISTORY UPDATE

1. Date: _____ **Comments:** _____ **Signature:** _____

2. Date: _____ **Comments:** _____ **Signature:** _____

3. Date: _____ **Comments:** _____ **Signature:** _____



American Dental Associates,Ltd./Archer Dental Specialists,Inc.
5342 S. Archer Avenue
773-284-1645/773-284-8540

Payment Expectation Policy:

As a courtesy to you, our patients, we accept most insurance plans and submit claims to those plans on your behalf. To do this efficiently, it is important that we have accurate and complete information on your insurance coverage. It is important that all your insurance plan's requirements are met prior to providing services, such as referrals.

It is your responsibility to pay for any co-payments, deductibles, and co-insurance required by your insurance plan, as well as any services not covered by your insurance plan. We are happy to provide you with any service(s) you need, however, if your insurance plan does not cover certain services, you will be responsible for payment. If we have not received payment from your insurance plan within 30 days after date of service, or the insurance plan has denied payment in part or in full, we reserve the right to defer the outstanding balance to you.

Payment is expected at time of service, as well as any prior balance you might owe. Patients without insurance are expected to make full payment at time of service or to make other arrangements prior to service. We accept the following forms of payment.

* Cash
* All Major Credit Cards
* Debit Cards
* Care Credit

We will bill outstanding balances to you monthly, and payment is due upon receipt. Account balances that have not been paid within 3 statement cycles will be turned over to a licensed collection agency. Payment of unpaid balances is expected prior to any new services being provided.

I have read, understand, and agree with the following guidelines.

Printed Patient Name: _____

Patient Signature: _____ ***Date:*** _____

American Dental Associates,Ltd./Archer Dental Specialists,Inc.
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To help our office run smoothly we ask for the following:

Payments:
All payments must be made at time of service. We do ***not*** accept personal checks.

Cancellation Policy:
We need to be notified of a ***cancellation a minimum of 24-hours in advance for 30-minute appointments & four business days in advance for 45-minute, 1-hour or more appointments*** or you will be charged a ***$20-$100 Cancellation Fee***, depending on length of appointment.

Insurance Disclaimer:
A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. If you have any questions please feel free to ask.

Deposit Procedures:
There will be a $20.00-$100.00 deposit taken to hold certain 30-minute, 45-minute, 1- hour or longer procedural appointments. Please ask for clarification if needed.

Refund Policy:
Refunds will be made to our patients (when deemed necessary) in the form or mode in which payments were initially made after all insurance statements have been cleared.

I have read, understand, and agree with the following policies.

Printed Patient Name: _____

Patient Signature: _____ ***Date:*** _____

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 April 14th, 2003 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 **$15.00** for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want 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, 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 for 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 the 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 received 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 may also 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 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: **DHIRAJ SHARMA, D.D.S.**

Telephone: **773-284-1645** Fax: **630-423-9646**

E-mail: **drsharma@atooth.com**

Address: **5342 S. ARCHER AVE**

Address: **CHICAGO, IL 60632**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
Date

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)

_____

_____

_____