NAPERVILLE DENTAL ASSOCIATES, LTD.

Hobson Medical Campus Suite 240
1220 Hobson Road
Naperville, IL 60540 (630) 369-0101
naperville-dental-associates.com

Your Information

Name: _____
Last First Mi. Mr. Mrs. Ms. Dr.

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate:____/____/____ Age:____SS#:_____/_____/____

Home address: _____
Apt.#

_____
City State Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Phone number: Home: _____

Work:_____Ext:_____

Cell: _____

E-Mail: _____

Employer: _____

Employer's address_____

Occupation: _____

_____

Whom may we thank for referring you? _____

Other family members seen by us?_____

_____

Previous dentist: _____

Last visit date: _____

Dental Insurance

Primary Dental Insurance

Insurance co. name: _____

Address: _____

Phone number: _____

Group or plan number: _____

Insured name:_____

SS#or ID#: _____

Insured employer:_____

Insured address:_____

Secondary Dental Insurance

Insurance co. name: _____

Address: _____

Phone number: _____

Group or plan number: _____

Insured name:_____

SS# or ID#: _____

Insured employer:_____

Insured address:_____

Spouse Information

Name: _____

Birthdate:____/____/____Age:____SS#_____/_____/_____

Employer:_____

Phone number: Home: _____

Work:_____Ext:_____

Cell: _____

Person responsible for this account: _____

Relationship:_____SS#_____/_____/_____

Billing address: _____

Phone number: _____

Account balances in excess of 60 days are subject to a service charge of 1½ per month, which equals 18% per annum. In the event of default in payment of any amount due and if this account is placed in the hands of an agency or an attorney for collections or legal action, then I, the undersigned, hereby agree to pay an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these actions.

We will prepare necessary forms and reports to help obtain benefits from your insurance company. All services are charged directly to the patient and that patient is personally responsible for payment of fees.

Signature:_____**Date:**_____

NAPERVILLE DENTAL ASSOCIATES, LTD.

Medical History

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

Please explain: _____

Are you taking any prescription or over the counter medications? Yes No

Please list each one: _____

_____

_____

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

Allergies	Hemophilia/Abnormal bleeding
Anemia	Hepatitis
Artificial joints	High/Low blood pressure
Artificial heart valve	HIV+/AIDS
Arthritis	Kidney problems
Asthma	Liver disease
Blood transfusions	Mitral valve prolapse
Cancer/Chemotherapy	Psychiatric problems
Congenital heart defect	Rheumatic fever
Diabetes	Scarlet fever
Drug/alcohol abuse	Sinus problems
Emphysema	Stroke
Epilepsy/seizures	Thyroid disease
Fever blisters/Herpes	Tuberculosis
Heart attack	Ulcers
Heart murmur	Venereal disease
Heart disease/pacemaker	X-ray/Radiation treatment

Please list any other medical conditions that you have had.

_____

_____

For Women Only

Are you taking birth control pills? Yes No

Are you pregnant/nursing? Yes No

Are you allergic to any of the following?

Anesthetics	Codeine	Latex
Aspirin	Erythromycin	Penicillin

Please list any other allergies: _____

_____

Dental History

Why have you come to the dentist today?

_____

_____

Are you currently in pain? Yes No

Do your gums bleed? Yes No

Have you had orthodontic treatment? Yes No

Have you ever had gum treatment? Yes No

Do you grind or clench your teeth? Yes No

Do you have any pain in your jaw joint(TMJ)? Yes No

Are your teeth sensitive to hot, cold, other? Yes No

Have you had any problem with previous dental work? Yes No

Do you like your smile? Yes No

If no, why?_____

_____

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

How often do you floss?_____Brush? _____

Type of brush? Hard Medium Soft

Date of last dental visit._____

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 confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____**Date:**_____

Reviewed _____By _____
Reviewed _____By _____
Reviewed _____By _____
Reviewed _____By _____

Reviewed_____ By_____
Reviewed_____ By_____
Reviewed_____ By_____
Reviewed_____ By_____

Naperville Dental Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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)

_____

_____

_____

Naperville Dental Associates

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 15, 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 $0.20 for each page, $10 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.

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 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 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 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: Karen Rudman

Telephone: 630-369-0101

Address: 1220 Hobson Road, Suite 240, Naperville, IL 60565