

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTH DATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
<hr/>				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTH DATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, PLEASE ALSO FILL IN THE TOP BOX

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs
2. Upon such diagnosis, I authorize 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 embodies 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's 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 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 arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1- 1/2% late charge (18% APR) may be added to my account, if required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent /Responsible Party's Signature _____ Relationship to Patient _____

Patient Name _____
Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both pages of this Medical History/Dental History form.

All information is held completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No
- Have you noticed any mouth odors or bad tastes? Yes No
- Do you frequently get cold sores, blisters or any other oral lesions? Yes No

- Do your gums bleed or hurt?** Yes No
- Have your parents experienced gum disease or tooth loss? Yes No
- Have you noticed any loose teeth or change in your bite? Yes No
- Does food tend to become caught in between your teeth? Yes No
- If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Snore or have any other sleeping disorders? Yes No
- Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Periodontal treatment? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
- If so, please describe, including cause _____

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neck aches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete next page)

Patient Name _____
Patient Account No. _____

MEDICAL HISTORY

Medical Alert _____

- Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address City _____ State _____ Zip _____
- Have you taken any medication or drugs during the past two years?..... Yes No
- Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? Yes No
 If yes, please list name and dosage _____
- Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)? Yes No
 If yes to the above, did you have a medical exam for heart issues? Yes No
- Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
 If yes, please list: _____
- Have you been a patient in the hospital during the past five years? Yes No
- Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack) Yes No	Ulcers Yes No	Hepatitis: A B C (circle) Yes No
Chest Pain Yes No	Diabetes Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Thyroid Problems Yes No	A.I.D.S. Yes No
Heart Murmur Yes No	Glaucoma Yes No	H.I.V. Positive Yes No
High Blood Pressure Yes No	Contact lenses Yes No	Cold Sores/Fever Blisters Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Blood Transfusion Yes No
Artificial Heart Valve Yes No	Chronic Cough Yes No	Hemophilia Yes No
Heart Pacemaker Yes No	Tuberculosis Yes No	Sickle Cell Disease Yes No
Rheumatic Fever Yes No	Asthma Yes No	Bruise Easily Yes No
Arthritis/Rheumatism Yes No	Hay Fever Yes No	Liver Disease Yes No
Cortisone Medicine Yes No	Latex Sensitivity Yes No	Yellow Jaundice Yes No
Swollen Ankles Yes No	Allergies or Hives Yes No	Neurological Disorders Yes No
Stroke Yes No	Sinus Trouble Yes No	Epilepsy or Seizures Yes No
Diet (Special/Restricted) Yes No	Radiation Therapy Yes No	Fainting or Dizzy Spells Yes No
Artificial Joints (hip, knee, etc.) Yes No	Chemotherapy Yes No	Nervous/Anxious Yes No
Kidney Trouble Yes No	Tumors Yes No	Psychiatric/Psychological Care Yes No
- Do you use more than two pillows to sleep?..... Yes No
- Have you lost or gained more than 10 pounds in the past year?..... Yes No
- Do you have or have you had any disease, condition, or problem not listed?..... Yes No
 If yes, please list: _____
- Women:** Are you pregnant or think you may be pregnant?.....Yes, ____ Months No **Nursing?**..... Yes No
- Women:** Do you use birth control medications?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

History Review

HIPAA Notice of Privacy Practices



DEARBORN DENTISTRY
539 SOUTH DEARBORN ST.
CHICAGO, IL 60605
(312) 913-2300
FAX: (312) 453-7232

JOHN A QUINN, DDS

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. .

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____