PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

BEST # TO CONFIRM @?

OK TO CONFIRM @WORK?

OK TO CALL CELL?

ADDITIONAL NUMBERS

NAME OF ADDITIONAL #

REFERRAL SOURCE?

REFERRAL SOURCE INFO

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

MEDICAL HISTORY

SINCE 1964 the Dental Store®

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain:	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain:	
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:	
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain:	
Are you taking, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No		
Are you on a special diet?	☐ Yes	☐ No		
Do you use tobacco?	☐ Yes	☐ No		
Do you use controlled substances?	☐ Yes	☐ No		

Women:
Are you Pregnant, Trying to get pregnant, or nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?
Aspirin ☐ Penicillin ☐ Codeine ☐ Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐
Other ☐ If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐	Yes	☐	No	Cortisone Medicine	☐	Yes	☐	No	Hemophilia	☐	Yes	☐	No	Radiation Treatments	☐	Yes	☐	No
Alzheimer's Disease	☐	Yes	☐	No	Diabetes	☐	Yes	☐	No	Hepatitis A	☐	Yes	☐	No	Recent Weight Loss	☐	Yes	☐	No
Anaphylaxis	☐	Yes	☐	No	Drug Addiction	☐	Yes	☐	No	Hepatitis B or C	☐	Yes	☐	No	Renal Dialysis	☐	Yes	☐	No
Anemia	☐	Yes	☐	No	Easily Winded	☐	Yes	☐	No	Herpes	☐	Yes	☐	No	Rheumatic Fever	☐	Yes	☐	No
Angina	☐	Yes	☐	No	Emphysema	☐	Yes	☐	No	High Blood Pressure	☐	Yes	☐	No	Rheumatism	☐	Yes	☐	No
Arthritis/Gout	☐	Yes	☐	No	Epilepsy or Seizures	☐	Yes	☐	No	High Cholesterol	☐	Yes	☐	No	Scarlet Fever	☐	Yes	☐	No
Artificial Heart Valve	☐	Yes	☐	No	Excessive Bleeding	☐	Yes	☐	No	Hives or Rash	☐	Yes	☐	No	Shingles	☐	Yes	☐	No
Artificial Joint	☐	Yes	☐	No	Excessive Thirst	☐	Yes	☐	No	Hypoglycemia	☐	Yes	☐	No	Sickle Cell Disease	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Fainting/Dizziness	☐	Yes	☐	No	Irregular Heartbeat	☐	Yes	☐	No	Sinus Trouble	☐	Yes	☐	No
Blood Disease	☐	Yes	☐	No	Frequent Cough	☐	Yes	☐	No	Kidney Problems	☐	Yes	☐	No	Spina Bifida	☐	Yes	☐	No
Blood Transfusion	☐	Yes	☐	No	Frequent Diarrhea	☐	Yes	☐	No	Leukemia	☐	Yes	☐	No	Stomach/Intestinal	☐	Yes	☐	No
Breathing Problem	☐	Yes	☐	No	Frequent Headaches	☐	Yes	☐	No	Liver Disease	☐	Yes	☐	No	Stroke	☐	Yes	☐	No
Bruise Easily	☐	Yes	☐	No	Genital Herpes	☐	Yes	☐	No	Low Blood Pressure	☐	Yes	☐	No	Swelling of Limbs	☐	Yes	☐	No
Cancer	☐	Yes	☐	No	Glaucoma	☐	Yes	☐	No	Lung Disease	☐	Yes	☐	No	Thyroid Disease	☐	Yes	☐	No
Chemotherapy	☐	Yes	☐	No	Hay Fever	☐	Yes	☐	No	Mitral Valve Prolapse	☐	Yes	☐	No	Tonsillitis	☐	Yes	☐	No
Chest Pains	☐	Yes	☐	No	Heart Attack/Failure	☐	Yes	☐	No	Osteoporosis	☐	Yes	☐	No	Tuberculosis	☐	Yes	☐	No
Cold Sore/Fever	☐	Yes	☐	No	Heart Murmur	☐	Yes	☐	No	Pain in Jaw Joints	☐	Yes	☐	No	Tumors/Growths	☐	Yes	☐	No
Congenital Heart	☐	Yes	☐	No	Heart Pacemaker	☐	Yes	☐	No	Parathyroid Disease	☐	Yes	☐	No	Ulcers	☐	Yes	☐	No
Convulsions	☐	Yes	☐	No	Heart Trouble/Disease	☐	Yes	☐	No	Psychiatric Care	☐	Yes	☐	No	Venereal Disease	☐	Yes	☐	No
Have you ever had any serious illness not listed above?	☐	Yes	☐	No											Yellow Jaundice	☐	Yes	☐	No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

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 la 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 04/01/03 , 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 according to the means outlined in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician/dentist 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 prescriptions, dental 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 Reminder: 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 format other than photocopies. We will use the format you request unless we cannot particularly 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 **$0.25** for each page, **$35.00** 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 summery or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for 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. This request must be 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. This 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 also entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you would like additional information about our privacy practices, have questions or concern, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of your 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 send your concerns to Aspen Dental's Corporate Offices, Attn: HIPAA Compliance. You also may submit written concerns to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.

We support your right to maintain 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 Office Manager: **Joel Cohn**

Telephone: **(847)301-0400 ext. 228**

E-mail: **admin@dentalstore.com**

Address: **1061 South Roselle Road, Schaumburg, IL 60193**

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; however; acknowledgement could not be obtained due to:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

_____
_____
_____

CONSENT & ACKNOWLEDGEMENT FORM

SINCE 1964 the Dental Store®

General Consent

The undersigned herby authorizes The Dental Store providers to take X-rays, study model, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in The Dental Store for myself or for my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge of 2.5% per month may be added to any overdue balance. I also assign all insurance benefits to the Doctor. Initials: _____

VELscope Screen Acknowledgement

The Dental Store recommends use of the VELscope along with a visual examination to screen for oral cancer. Oral cancer is the sixth most commonly diagnosed cancer, and with early detection the survival rate increases significantly. In its early stages, oral cancer can be painless and physical changes may be difficult to notice. The VELscope is a diagnostic tool that uses light to detect abnormal tissue. If abnormal tissue is detected by your clinician you may be referred to a specialist for further evaluation. There is no pain involved nor is harmful radiation emitted.

I Consent to allow use of the VELscope. I understand my insurance may not cover the fee. Initials: _____

Oral Health Risk Factor Screening

1 Circle all that you currently use or have a history of using (Circle all that apply): Cigarettes, Cigars, Pipes, Other Tobacco
Explain how often _____

2	Yes	No	Do you consume alcohol?	If yes, how often? _____
3	Yes	No	Have you ever been diagnosed with a substance abuse problem?	If yes, describe _____
4	Yes	No	Do you use or have a history of using recreational drugs?	If yes, which ones and how often _____
5	Yes	No	Have you ever been diagnosed with an eating disorder?	If yes, describe _____
6	Yes	No	Do you have or have you had any neck or mouth piercings?	If yes, describe _____
7	Yes	No	Have you been diagnosed with HPV Human Papilloma Virus?	
8	Yes	No	Do you or your family have a history of cancer?	If yes, describe _____

Notice of Privacy Practices Receipt Acknowledgement

*You May Refuse to Sign this Acknowledgement

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. Initials: _____

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices; however; acknowledgement could not be obtained due to:
□ Individual refused to sign □ Communication barriers prohibited obtaining the acknowledgement □ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify) _____

Obstructive Sleep Apnea Acknowledgement

I acknowledge that The Dental Store is providing a Obstructive Sleep Apnea screening. Initials: _____

Obstructive Sleep Apnea Screening

1	Yes	No	Do you snore loudly (Louder than talking or loud enough to be heard through a closed door)?
2	Yes	No	Do you feel tired, fatigued, or sleepy during the day?
3	Yes	No	Has anyone observed you stop breathing during your sleep?
4	Yes	No	Do you have or are you being treated for high blood pressure?

I Consent to or Acknowledge each section of this form as indicated by my initials

_____ Patient Name (Printed)

_____ Patient Signature (Parent or Guardian for minor)

_____ Date