EVANSTONDENTALASSOCIATES, LTD

Joseph B. Silberman, DMD, MAGD

Patient Registration Form

Today's Date _____

Name _____

Address_____

City _____State _____Zip_____

Home Phone _____ Work _____ Cell _____

Birthdate ____ /____ / ____ ❑ Male ❑ Female Marital Status ❑S ❑M ❑P ❑D ❑ W

Email _____

Best method to contact you_____

Social Security Number _____ - _____ - _____

How were you referred to our office?_____

Do you use the following? ☐ Facebook ☐ Yelp ☐ Twitter ☐ Google+ ☐ None Of Them

What is your favorite movie? _____

What kind of music do you like? _____

Responsible Party's Name (if different from above) _____

Relationship to Patient _____

Address _____

City _____State _____Zip_____

Home Phone _____ Work _____ Cell _____

Social Security Number _____ - _____ - _____

Person to contact in an emergency:

Name_____ Phone Number _____

Today's Date_____

Sponsor of Plan Name _____

Sponsor Address _____

_____

Primary Dental Insurance Company _____

Mailing Address for Dental Claims _____

_____

Member/Subscriber Name _____ Date of Birth _____/_____/_____

Relationship to subscriber ❑ self ❑ spouse ❑ dependent

Group Number _____Subscriber ID Number _____

Secondary Dental Insurance Company _____

Mailing Address for Dental Claims _____

_____

Member/Subscriber Name _____ Date of Birth _____/_____/_____

Relationship to subscriber ❑ self ❑ spouse ❑ dependent

Group Number _____Subscriber ID Number _____

Full payment is expected at the time of service, unless prior arrangements have been made. As a courtesy, we are happy to submit insurance forms on your behalf. In order to do this, we must have your correct insurance information on file. Please read your policy carefully. We strive to provide the most appropriate quality treatment for our patients. Some or all of the service we provide may not be a covered benefit. Please be aware of your insurance plan's limitations, exclusions and plan maximums. The entire account balance remains your responsibility.

Joseph B. Silberman, DMD, MAGD

Welcome! So that we may provide you with the best possible care, please complete the entire dental history form. All information will be kept completely confidential.

Today's Date_____

Purpose of your visit today _____

_____

Previous Dentist's Name_____

Address _____ City _____ State _____ Zip _____

Phone_____

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

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

Are any of your teeth sensitive to: (check all that apply) ❑ Hot ❑ Cold ❑ Sweets ❑ Biting ❑ Chewing

If yes, where? _____

Have you noticed any mouth odors or bad tastes? ❑ Yes ❑ No

Do you ever get cold sores, blisters or any other mouth/lip lesions? ❑ Yes ❑ No

Have you noticed any loose teeth or a change in your bite? ❑ Yes ❑ No

Does food tend to get caught in between your teeth? ❑ Yes ❑ No

Do you:

Clench or grind your teeth?	❑ Yes ❑ No	Smoke/chew tobacco?	❑ Yes ❑ No
Have tired jaws (esp. in the morning)?	❑ Yes ❑ No	Breathe through your mouth?	❑ Yes ❑ No
Frequently bite your lips or cheeks?	❑ Yes ❑ No	Hold foreign objects in your teeth?	❑ Yes ❑ No

Have you experienced:

Clicking/popping of the jaw?	❑ Yes ❑ No	Difficulty opening/closing your mouth?	❑ Yes ❑ No
Difficulty chewing?	❑ Yes ❑ No	Headaches, neck pain or shoulder pain?	❑ Yes ❑ No

Have you ever had:

Orthodontic treatment?	❑ Yes ❑ No	Oral Surgery?	❑ Yes ❑ No
Periodontal (Gum) treatment?	❑ Yes ❑ No	Your teeth ground or your bite adjusted?	❑ Yes ❑ No
A bite plate or mouth guard?	❑ Yes ❑ No	A serious injury to your mouth or head?	❑ Yes ❑ No

If yes, please describe _____

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No If no, please describe _____

_____

Do you feel nervous about having dental treatment? ❑ Yes ❑ No If yes, what is your biggest concern?

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

EVANSTONDENTALASSOCIATES, LTD

Joseph B. Silberman, DMD, MAGD

Medical History Form

Patient Name

Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

If yes, for what? _____

Physician's Name _____

Are you taking any medications now? ❑ Yes ❑ No If yes, please list name and dosage:

_____

Are you allergic or have adverse reaction to any medications? ❑ Yes ❑ No If yes, please list them:

_____

Do you have a latex allergy? ❑ Yes ❑ No

Have you been hospitalized during the past five years? ❑ Yes ❑ No If yes, please describe:

_____

Indicate which of the following you have had, or have at present:

Heart (Surgery, Disease, Attack)	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Mitral Valve Prolapse	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Chronic Cough	❑ Yes ❑ No
Heart Pacemaker	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Arthritis/Rheumatism	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No
Swollen ankles	❑ Yes ❑ No	Sinus trouble	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No
Artificial joints	❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No
Kidney trouble	❑ Yes ❑ No	Tumors	❑ Yes ❑ No
Hepatitis A,B,or C	❑ Yes ❑ No	Venereal disease	❑ Yes ❑ No
AIDS	❑ Yes ❑ No	HIV positive	❑ Yes ❑ No
Blood transfusion	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Sickle Cell disease	❑ Yes ❑ No	Bruise easily	❑ Yes ❑ No
Liver disease	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No
Neurological disorders	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No
Fainting or dizzy spells	❑ Yes ❑ No	Psychological Care	❑ Yes ❑ No

Have you ever been treated with Botox or Dermal Fillers (Restylane, Juvaderm)? ❑ 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? ❑ Yes, ____ months ❑ No Are you nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ 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 doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Evanston Dental Associates

{NAME OF PRACTICE}

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 08/01/13, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more in formation about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if 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.

Our Privacy Official: Joseph B. Silberman, DMD, MAGD

Telephone: 847-864-2243 Fax: 847-864-2270

Address: 500 Davis St. Suite 510 Evanston, IL 60201

Email: DrJoe@Evanston-Dental.Com

© 2010, 2013 American Dental Association. All Rights Reserved.

* You May Refuse to Sign This Acknowledgment*

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

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)

© 2010, 2013 American Dental Association. All Rights Reserved.

1. I hereby authorize Dr. J. Silberman, Dr. J. Marsek, or designated staff to take x-rays, impressions for study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s needs.

2. Upon such diagnosis, I authorize Dr. J. Silberman or Dr. A. Silberman 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. There is a fee of $55 per appointment hour for any missed appointment and/or cancelled appointment with less than 48 hours notice.

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 advance.

Patient Signature _____Date_____

Responsible Party _____

Relationship to Patient _____