WELCOME

This information is important for us to know in planning your dental treatment. This information is, of course, confidential. Please fill out this form as completely as you can. Thank you!

Patient's Name:	Date of Birth:		
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Social Security #:	Email Address:		

For Child	
Father's Full Name:	Mother's Full Name:

For Adult ❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** ❑ **Miss** ❑ **Dr.** ❑ **Other**	
Should the need arise may we contact you at work regarding your appointment? ❑ Yes ❑ No	Work Phone:
Patient's Employer:	Position/Department:
Spouse's Full Name & Employer	

Account Information (Insurance information on separate form)	
Name of person responsible for account:	Do you have dental insurance? ❑ Yes ❑ No
Employer:	
Name and Phone of person to contact in case of emergency:	
Whom may we thank for this referral?	

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The medical information on this form is accurate to the best of my knowledge.

Signature (parent or guardian if a minor): ____ Date: ______________

Medical / Dental History	
Name & Address of Physician:	Date of Last Medical Visit:

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2932 Finley Road, Downers Grove, IL 60515
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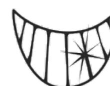
dentalwellnesschicago.com



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Medical/Dental History (continued)
Are you now under the care of a physician? ❑ Yes ❑ No
If you answered yes above, for what reason?
List all medications, drugs and/or vitamin supplements with dosages that you are taking:

Please check any of the following that apply to you (now or in the past):

- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Artificial Heart Valve
- ❑ Congenital Heart Defect
- ❑ Abnormal Blood Pressure
- ❑ Ulcers
- ❑ Tuberculosis, Lung disease
- ❑ Diabetes
- ❑ Excessive urination, thirst
- ❑ Autoimmune Disease
- ❑ Epilepsy, Convulsions
- ❑ Anemia
- ❑ Thyroid Problem
- ❑ Chemical Dependency
- ❑ Abnormal Bleeding
- ❑ Fainting Spells
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Asthma, Hay Fever
- ❑ Cancer
- ❑ Sinus problems
- ❑ Tumours - explain
- ❑ Stroke
- ❑ Glaucoma
- ❑ Radiation Therapy - explain
- ❑ Mental Health Care
- ❑ Knee or hip replacement
- ❑ Venereal Disease
- ❑ Arthritis
- ❑ Acid Reflux - GERD
- ❑ HIV
- ❑ Other
- ❑ Pregnant, due: _______________
- ❑ Nursing
- ❑ Allergies:
  - ❑ Penicillin
  - ❑ Codeine
  - ❑ Local Anesthetic
  - ❑ Latex
  - ❑ Other ____________________
  - __________________________
  - __________________________
  - __________________________

When was your last dental cleaning?	Have you had dental x-rays taken in the last two years? ❑ Yes ❑ No
Are you aware of a dental problem? If yes, explain:	
In the past have you had any problems during dental appointments? ❑ Yes ❑ No	
If you answered yes above, please explain:	

Please check any of the following that apply to you (now or in the past):

- ❑ Gums bleed
- ❑ Gums disease
- ❑ Food collects
- ❑ Grinding or clenching
- ❑ Use tobacco products
- ❑ Jaw joint noise
- ❑ Locked jaw
- ❑ Unpleasant Taste
- ❑ Mouth sores
- ❑ Bite is off
- ❑ Teeth sensitive to sweets
- ❑ Teeth sensitive to cold
- ❑ Teeth sensitive to heat
- ❑ Teeth sensitive to pressure
- ❑ Chronic Headache
- ❑ Chronic neck pain
- ❑ Ear pain
- ❑ Teeth stain
- ❑ Braces
- ❑ Gum treatment

I have seen and read this Medical/Dental history. DDS Signature: ____ Date: ______________

Medical Updates (STAFF USE) Note changes, date & sign.		
Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes
Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes

WRITTEN FINANCIAL POLICY

Thank you for choosing Basciano & Associates. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You may choose from:

- We offer a **5% courtesy discount** to patients who pay for their treatment with cash or check prior to completion of care.
- We also offer a **3% discount** for full payment with MasterCard or Visa, American Express or Discover.
- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allows you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A fee of $50 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

Basciano & Associates charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Signature (patient or parent if minor): ____ Date: ________________

Patient Name (please print): ____

[1] If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2] Subject to credit approval

[3] However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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INSURANCE - ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

Primary Carrier

Name of Insured: Date of Birth:

Employer: How long employed:

Name of Insurance Company:

Mailing Address:

Employee SS# or ID#: Group or Policy#:

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of the dental treatment.

Signature (patient or parent if minor): ____ Date: ________________

I hereby authorize payment directly to the named dentist of the group insurance benefits otherwise payable to me.

Signature (patient or parent if minor): ____ Date: ________________

Secondary Carrier

Name of Insured: Date of Birth:

Employer: How long employed:

Name of Insurance Company:

Mailing Address:

Employee SS# or ID#: Group or Policy#:

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of the dental treatment.

Signature (patient or parent if minor): ____ Date: ________________

I hereby authorize payment directly to the named dentist of the group insurance benefits otherwise payable to me.

Signature (patient or parent if minor): ____ Date: ________________

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PRIVACY RELEASE AND DISCLOSURE STATEMENT

Name: ____ Date of Birth: ________________________

Parent or Guardian of: ____

*I acknowledge that I have read or received a copy of the **Notice of Privacy Practices** from Basciano & Associates.*

Signature: ____ Date: _______________________

*I have declined to read or receive a copy of the **Notice of Privacy Practices** from Basciano & Associates.*

Signature: ____ Date: _______________________

Notes: ____

PATIENT RECORD OF DISCLOSURE

In general, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules give individuals the right to request that confidential communication or any communication of protected health information be made by alternative means. For example, sending correspondence to the individual's place of business instead of an individual's home.

I, ____, wish to be contacted in the following manner:

Please check ALL that apply.

- ❑ **Home Telephone Number**: ______________________________
- ❑ Okay to leave message with detailed information
- ❑ Leave message with call back number only
- ❑ **Work Telephone Number**: _______________________________
- ❑ Okay to leave message with detailed information
- ❑ Leave message with call back number only
- ❑ **Written Correspondence**
- ❑ Okay to mail to HOME address
- ❑ Okay to mail to WORK address
- ❑ Okay to FAX to this number: ______________________________
- ❑ **OTHER**: ____

Signature: ____ Date: _______________________

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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

Federal and state law requires us to maintain the privacy of your health information. That same law also requires that you receive this notice about our privacy practices, our legal responsibilities, and your rights concerning your health information. We must follow the privacy practices that we describe in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy policy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make 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 this notice at any time. For more information about our privacy practice or for additional copies of this notice, please contact us.

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 and disclose your health information for treatment or disclose it to a dentist, physician, or other health care provider providing treatment to you.

Payment: We may use or disclose your health information to acquire payment for services that we provide to you. We may also disclose your health information to other health care providers that are subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations consist of quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to other health care providers or organizations that are subject to the federal privacy rules and that have a relationship with you to support some of their health care operations. We may also disclose your health information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect and prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health care information or to disclose it to anyone for any reason. If you give us an authorization, you may cancel it at any time. The cancellation will not affect any uses or disclosures permitted by your authorization while it was in effect. We may not use or disclose your health information for any reason except those described in this notice unless you give us a written authorization.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or payment for your health care. Before we disclose your health information to these people, we will give you an opportunity to oppose to our use of disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether it would be in your best interest to disclose. We will use our professional judgment and our experience with common practice to make reasonable assumption of your best interest in allowing a friend or family member to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify (assist in notifying) a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for purposes stated below believed to be in the public interest or benefit:

- as required by law;
- for public health activities, as well as disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight organizations;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our grounds, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other persons
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with selected research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional associations regarding inmates;
- as authorized by states worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health care information, with limited exceptions. You may request that we provide copies in a format other then photocopies. Unless we cannot do so for any reason, we will use the format you request. You must make a request in writing to obtain access to your health care information. You may do so by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee. Feel free to contact us for more information about fees using the information listed at the end of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). This list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once within a period of 1-year, we may charge you a reasonable, cost-based fee for responding to these additional requests. For more information about fees, contact us using the information listed at the end of this notice.

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, however, if we do, unless in an emergency, we will abide by our agreement. Any agreement we may make to a request for additional restrictions must be in writing, signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we convey with you your health information by alternative means or to alternative locations. This request must be in writing; you must specify in your request the alternative means or location, and provide a satisfactory explanation about how you will handle payment 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, explaining why we should amend the information. Under particular circumstances, we may deny your request.

QUESTIONS AND COMPLAINTS

Please contact us using the information listed at the end of this notice if you want more information about our privacy practices or have questions or concerns.

If you believe that:

- we may have violated your privacy right;
- we made a decision about access to your health information incorrectly;
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect; or
- we should communicate with you by alternative means or locations

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. Upon request we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. 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.

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