WELCOME

PATIENT INFORMATION: Today's Date:_____

Name: _____ Date of Birth: _____
LAST FIRST MI

Preferred Name_____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ E-Mail:_____

Address: _____
Street Address City State Zip

Gender:_____ Married Single Divorced Widowed Other

In case of an emergency, who should be notified: _____ Phone Number:_____

Please indicate how you would like your upcoming appointments to be confirmed via:

Call: ___ Email: ____ Text: _____ Whom may we thank for referring to you:_____

HEALTH HISTORY

Date of Last Dental Visit:_____ Reason for Today's Visit:_____

Have you **ever** had any of the following? Please Check all that apply:

- o AIDS/HIV Positive
- o Alzheimer" Disease
- o Allergies
- o Anaphylaxis
- o Anemia
- o Arthritis
- o Artificial bones/joints
- o Artificial Heart valves
- o Asthma
- o Blood Disease
- o Blood Transfusion
- o Blood Thinners
- o Breathing problems
- o Cancer
- o Chemotherapy
- o Chest Pain
- o Cold Sores/Fever Blister
- o Congenital Heart Disorder
- o Convulsions
- o Diabetes
- o Dizziness
- o Emphysema
- o Epilepsy
- o Excessive Bleeding
- o Frequent Headaches
- o Frequent Cough
- o Genital Herpes
- o Glaucoma
- o Hay Fever
- o Herpes
- o Heart Attack
- o Heart Murmur
- o Heart Pacemaker
- o Hemophilia
- o High Blood Pressure
- o High Cholesterol
- o Hypoglycemia
- o Irregular Heartbeat
- o Jaundice
- o Kidney Stones
- o Leukemia
- o Liver Disease
- o Low Blood Pressure
- o Lung Disease
- o Mitral Valve Prolapse
- o Osteoporosis
- o Pain in Jaw
- o Parathyroid Disease
- o Psychiatric Care
- o Radiation Treatments
- o Recent Weight Loss
- o Stomach/Intestinal Disease
- o Tuberculosis
- o Tumors or Growths
- o Ulcers
- o Venereal disease
- o Sickle Cell
- o Stroke
- o Swelling of Limbs
- o Thyroid Disease
- o Tonsillitis

Have you ever had any seriously illness not listed above?_____
_____

1. Have you ever had any complications following dental treatments? Yes No
If yes, please explain. _____

2. Have you been hospitalized or needed emergency care during the past two years? Yes No
If yes, please explain. _____

3. Are you now under the care of a physician..... Yes No

If so, what is the condition being treated? _____Physician's Name:_____

Address: _____Phone #:_____

4. Date of last medical examination_____

5. Have you had a joint replacement? Yes No
Have you ever been told to take pre-medication prior to a dental appointment? Yes No

6. Have you had excessive bleeding requiring special treatment? ..... Yes No

7. Are you currently taking any medication? .....**PLEASE USE NEXT PAGE**..... Yes No

8. Are you **Allergic** or have you ever experienced any reaction to the following?

Local Anesthetics (e.g. Novocain) _____ Codeine or other Narcotic _____

Barbiturates/Sedatives/Sleeping Pills_____ Sulfa Drugs_____Aspirin _____

Penicillin/Other antibiotics_____ Latex_____

9. Have you ever taken Fosamax, Boniva, Actonel, or any medications containing Bisphosphonates?_____

WOMEN:

Are you pregnant? Yes No Are you nursing? Yes No

Are you taking Birth Control Pills? (Antibiotics may make birth control pills ineffective) Yes No

DENTAL HISTORY

1. Do you prefer local anesthetic (Novocain) for most dental treatment Yes No

2. Does dental treatment make you nervous? No Slightly Moderately Extremely

3. Have you ever been treated for periodontal disease (Gum Disease, Pyorrhea, Trench Mouth). Yes No
If so, when?

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4. Do you have or have you ever had the following?

Bleeding Sore Gums	Yes	No	Loose Teeth.....	.....Yes	No	Biting Cheeks/Lips	Yes	No
Unpleasant Taste/Bad Breath	Yes	No	Sensitive to Hot.....	... Yes	No	Clenching/Grinding	Yes	No
Burning Tongue/Lips	Yes	No	Sensitive to Cold.....	Yes	No	Clicking/Popping Jaw	Yes	No
Frequent Blisters, Lips, Mouth	Yes	No	Sensitive to Sweets.....	... Yes	No	Complication from Extractions	Yes	No
Difficulty opening or closing jaw	Yes	No	Cigarettes, Pipe or cigar smoker	Yes	No			

River Walk DENTAL

NAME OF DRUG	DOSE/MG	HOW OFTEN	NOTES

Spouse or Responsible Party

The following is for: Patient_____ Spouse_____Person responsible for payment._____

Name:_____Gender:_____ Date of Birth_____
Last First MI

Social Security #_____ Home Ph:_____ Cell:_____

Address: _____
(IF DIFFERENT THAT PATIENT) **Street Address** **City** **State** **Zip**

Employment Information

The following is for Patient_____ The person responsible for payment_____

Occupation:_____ Position:_____How long?_____

Address: _____
Street Address City State Zip Phone

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of insured: _____Is the insured the patient? Yes No
Last First MI

Insured Birth Date: _____ Phone: _____ Email:_____

Insured's Address: _____
(IF DIFFERENT THAT PATIENT) Street Address City State Zip

Patients' relationship to patient: Self ___ Spouse_____ Child_____ Other_____

Name of insurance company:_____**Member ID**_____ Group#_____

Insurance Address: _____
Street Address City State Zip Phone number

SECONDARY DENTAL INSURANCE

Name of insured: _____Is the insured the patient? Yes No
Last First MI

Insured Birth Date: _____ Phone: _____ Email:_____

Insured's Address: _____
(IF DIFFERENT THAT PATIENT) Street Address City State Zip

Patients' relationship to patient: Self ___ Spouse_____ Child_____ Other_____

Name of insurance company:_____**Member ID**_____ Group#_____

Insurance Address: _____
Street Address City State Zip Phone number

River Walk DENTAL

OFFICE POLICY

Method of payments: Cash____ Check_____ Credit Card (Mastercard, Visa, American Express, Care Credit)
There is a minimum charge of $25.00 for all returned checks.

******WE DO REQUIRE A 24 HOUR CANCELLATION NOTICE******

There is a 25.00 charge per patient for any appointment cancelled without 24-hour notice. When making an appointment, remember that time is reserved for you.

Name of person we can discuss financials or billing with:_____
Name Relationship

_____ _____
Signature Today's Date

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred for their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment for all dental services. This office will help prepare patient's insurance forms and or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize my insurance company to send benefits to the office of Dr. Baibel.

I understand that the fee estimates listed for this dental care can only be extended for a period of 6 months from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefor the reasonable value of said services to said Doctor, or assignee, at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, within the time for payment thereof. I further agree to waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and Reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions and treatment and payment and agree to the content

_____ Date:_____Relationship to patient:_____
Signature of patient, parent, or guardian

_____ Date:_____Relationship to patient:_____
Signature of patient, parent, or guardian

RIVERWALK DENTAL

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 (4/14/2003), 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 $25 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 this contact information: Contact Officer: Teresa Souri

Telephone: 847-818-3384 Fax: 847-818-1207

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.

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 your name.

_____

Signature

_____

Date

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES; HOWEVER, ACKNOWLEDGEMENTS COULD NOT BE OBTAINED BECAUSE:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (Please specify)