PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE _____

ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS# _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN _____

_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ AGE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month _____
- ☐ Venereal disease
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

JEFFREY J. MARKETT, D.D.S.

426 W. 22nd Street
Lombard, IL 60148
Telephone: (630) 520-5552
Fax: (630) 620-5295

Written Financial Policy

Thank you for choosing Jeffrey Markett DDS. 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 can choose from:

-Cash, Check, Visa, Mastercard, or Discover Card
-NO INTEREST Payment Plans[2] from CareCredit
- Allow 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:

Our office requires payment prior to the completion of your treatment.
If you choose to discontinue care before treatment is completed, your refund will be determined upon review of your case.

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] We will also offer a discount to our patients without insurance that pay in full by cash or check the same day that the services are rendered, provided no other courtesies have been extended.

For any procedures requiring lab fees, our office requires a minimum initial payment of 50% of the patient's total responsibility at the first appointment to defray lab costs.

Our office charges $75.00 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.

Patient, Parent or Guardian Signature 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 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Dental Appointment Cancellation Policy

Dear Patient,

We strive to provide excellent dental care to you, your family, and all our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for patient.

"No-show," and late cancellations inconvenience those individuals who need access to dental care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Dental Appointment Cancellation Policy and it is effective July, 1 2018.

Our policy is as followed:

Cancellation of Appointment

In order to be respectful of the dental needs of other patients, please be courteous and alert our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely dental care.

How to Cancel Your Appointment

To cancel your appointment, please call (630) 620 5552. If you do not reach the front office, you may leave a detailed message with the answering service. If you would like to reschedule your appointment, please leave your name and number. We will return your call promptly.

Late Cancellations

A cancellation is considered to be late when the appointment is cancelled without a 24-hour advance notice. We will consider this as a missed appointment and a $50.00 no-show fee will be assessed to your account. This applies to late cancellations as well as "no-show" appointments.

I have read and understand the Dental Appointment Cancellation Policy and agree to the terms of this policy.

_____

Signature Date

_____

Printed Name

Oral ID Cancer Screening Acceptance Form

Our practice is constantly striving to provide important enhancements in oral health care for our patients. To this end, we would like to announce **ORAL ID**. **ORAL ID** is a fluorescence technology which allows us to shine a blue light that can identify oral cancer, pre cancer, and other abnormal lesions at an earlier stage.

As with most cancers age is the primary risk for oral cancer, though tobacco use is a major risk factor for oral cancer.

- 1 out of 2 men will develop cancer in his lifetime.
- 1 out of 3 women will develop cancer in her lifetime.
- The number of oral cancers has increased over a 6yr period where all other cancers have declined.
- HPV transmitted through sexual and skin to skin contact is the cause of the fastest growing oral cancer population; under the age of 45 and is responsible for a 15x increase in oral cancer diagnosis.
- There are 4x more cases of oral cancer than cervical cancer.
- 60% of oral cancers are in patients that do not smoke or drink alcohol.

We find that using **ORAL ID** along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly may save your life.

Dental insurance might not cover the **ORAL ID** exam. However, we will be more than happy to verify your coverage for you and will provide you with all documents needed for insurance purposes. The fee for this examination is $35.00

YES. I authorize the clinician to perform the ORAL ID exam along with the standard oral cancer exam. I accept financial responsibility for this enhanced examination.

Print Name:_____

Signature: _____ Date:_____

NO. I would prefer not to have the ORAL ID exam at this time.

Print Name:_____

Signature: _____ Date: _____

JEFFREY MARKETT, D.D.S.

{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.
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 04/15/03, 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 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 $0.50 for each page, $50.00 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 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 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.

Contact Officer: JEFFREY MARKETT

Telephone: 630-620-5552 Fax: 630-620-5295

E-mail: n/a

Address: 426 W. 22nd St., Lombard, IL. 60148

JEFFREY MARKETT, D.D.S.

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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, 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)

_____

_____

_____

We are currently updating/confirming our records. Please print the following:

Name _____
(first and last)

Cell phone number _____ []

Home Phone number _____ []

Work number _____ []

Email Address _____ []

Please indicate where you would like you appointment confirmed.