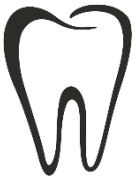
Welcome 

We are delighted that you have chosen Marcus Dental Practice for all your oral healthcare needs! Our staff all share a passion for excellence and a commitment to providing the highest level of care to our patients. Please take a minute to review the following information and fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

Patient Information

Patient Name: _____ _____ Todays Date: _____
First MI Last (Preferred Name)

Gender: _____ Mr.____ Mrs.____ Miss. ____Dr.____ Other _____ Date of Birth: _____

Address: _____
Street Unit # City State Zip

Social Security#_____ Email: _____

Phone # (Home) _____ (Cell)_____ (Work)_____

Marital Status: Single: _____ Married: _____ Divorced: _____ Separated: _____Widower: _____

Patient Employed By: _____ Occupation: _____

Dental History

Date of Last Dental Visit: _____ Reason for this visit: _____

What would you like accomplished today? _____

Are you in dental discomfort today? _____ Former Dentist: _____

Former Dentist Phone # _____ Date of last x-rays: _____

Have you ever had any unpleasant experience with dental treatment or a dentist in the past? Yes ___ No ___
If yes, please explain: _____

How do you feel about the appearance of your teeth? _____
Do you wish your teeth were straighter? Yes ___ No ___Do you wish you teeth were whiter? Yes ___ No ___
Are you unhappy with any fillings, crowns, or bridges? _____

Dental History Continued...

Have you had any with any of the following? Please check those that apply:

Bad breath ___
Bleeding gums ___
Clicking or popping jaw ___
Food collection between teeth ___
Grinding or clinching teeth ___
Loose or broken teeth ___
Periodontal treatment ___
Sensitivity to cold ___
Sensitivity to hot ___
Sensitivity to sweets ___
Sensitivity when biting ___
Sore or growths in mouth ___
Dry mouth ___
Facial Pain ___

Medical History

Have you had any with any of the following? Please check those that apply:

AIDS ___
Anemia ___
Arthritis ___
Artificial Joints ___
Asthma___
Autoimmune Disease ___
Back Problems ___
Cancer or Tumor ___
Chemotherapy ___
Diabetes ___
Digestion Disorder ___
Emphysema ___
Glaucoma ___
Hay Fever ___
Headaches ___
Heart Murmur ____
Hepatitis ___
High Blood Pressure ___
HIV+ ___
Hormone Disorder ___
Kidney Problems ___
Liver Disease___
Low Blood Pressure ___
Mitral Valve Prolapse ___
Neck Problems ___
Nervous Problems ___
Pins/Plates/Screws ___
Psychiatric Care ___
Radiation Treatment ___
Rheumatic Fever ___
Sinus Problems ___
Sjogren's Syndrome ___
Stomach Problems ___
Stroke ___
Systemic Lupus ___
Tuberculosis ___

Other _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes ___ No ___
If yes, please explain: _____
Do you require premedication? Yes ___ No ____ If so, what medications? _____

Are you under the care of a physician? Yes ___ No ___
Name of Physician: _____ Phone: _____

Have you ever had a sleep test preformed? Yes ___ No ___
Have you been diagnosed with sleep apnea? Yes ___ No ___
Do you use a CPAP? Yes ___ No ___
Do you snore? Yes ___ No ___
Is it easy for you to fall asleep? Yes ___ No ___
Do you stay asleep? Yes ___ No ___
Do you wake up with a headache? Yes ___ No ___
Do you have a history of headaches? Yes ___ No ___ Please describe: _____
How many mornings do you awaken feeling refreshed? _____

Are you pregnant? Yes ___ No ___
If yes, how far along are you? _____

Medications

What medications are you taking now and for what reason?

Medication/ Reason Medication/ Reason Medication/ Reason

1._____ 2. _____ 3. _____
4._____ 5. _____ 6. _____
7._____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

Are you taking aspirin or blood thinners daily or weekly? _____

Other: _____

Allergies

Are you allergic to or have any known sensitivity to metals like gold, copper, nickel, silver, or any other metals?

_____

Are you allergic to Penicillin, Codeine, or Aspirin? _____Other Drugs? _____

Are you allergic to anything else? _____

Dental Insurance Information

Subscriber Name: _____ Patient Name: _____
Subscriber Date of Birth: _____ Patient Date of Birth: _____
Subscriber Social Security Number: _____ Insurance Phone Number: _____
Employer Name: _____ Insurance ID Number: _____
Insurance Carrier: _____ Group Number: _____

Emergency Contact Info

Name: _____ Relationship to patient: _____
First MI Last
Address: _____ Phone Number: _____

Referral Information

Whom may we thank for referring you to our practice? Another Patient, friend ___ Another patient, relative___
Dental Office ___ Internet ___ Social Media ___Other ____

Name of person or office referring you to our office: _____

Responsible Party Information

The following is for the person responsible for payment.

First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Responsible Party Signature: _____

To the best of my knowledge, the preceding information provides is correct. If I ever have a change in my health, insurance, emergency numbers, employment, address, responsible party, or medications, I will inform the practice.

Name: _____ Signature: _____ Date: _____

CONSENT FOR SERVICES

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. Our office is NOT contracted with any insurance policies. As a courtesy to you we will help you process your dental insurance claim. Payment in full is due the time services are rendered, unless a payment agreement has been arranged.

Payment agreements that are more than 5 days past the original due date will be assessed a $25 late fee. If the due date falls on a weekend, holiday, or a day the office is not open, payment will be processed on the following business day. Failure to make monthly payments on time will result in discontinuation of treatment until the payment agreement is up to date.

MISSED APPOINTMENTS

Unless cancelled 48 hours in advance, our policy is to charge a fee of $50 for missed appointments. Please help us service you better by keeping scheduled appointments.

By signing this form, I understand and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

Name: _____ Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I (print name) _____, have received a copy of this office's privacy policy and agree to the terms and conditions. Please note that you may refuse to sign this acknowledgment.

Signature: _____ Date: _____

Office Use Only: We attempted to obtain written acknowledgment of receipt of our privacy policy, but acknowledgment could not be obtained because: Individual refused to sign___ Communication barrier ___ Emergency prevented us from obtaining acknowledgment ___ Other (please specify) _____

NOTICE OF PRIVACY PRACTICES

Michael B Marcus, D.D.S., Ltd.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal 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 April 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 policy 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. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

PAYMENT: We may use or 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 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 consent.

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 official's 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 or email 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. We can email your information for free. If you request copies, we will charge you a $20 fee for personnel 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.

DISCLURE 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

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 by written communication 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 website, or by electronic mail (email), 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 a 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 alternate 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: Noelle Hughes or JoAnn Adams

Address: 111 N Wabash Ave, Ste 2103, Chicago, IL. 60602

P. 312.263.6898 F.312.263.7565

E-mail: info@michaelmarcusdds.com