Welcome to Round Lake Family Dentistry! Thank you for choosing us to care for your family's dental needs. We look forward to developing an ongoing relationship with you.

Enclosed you will find registration forms containing the information we need for your chart. We will need a photo ID (i.e. state driver's license) and any dental insurance cards.

Please notify us if you have secondary dental insurance.

INSURANCE AND FINANCIAL POLICIES

If you plan to use dental insurance, please review your benefit book to better understand your coverage. Every plan is different but we will gladly review yours with you and try to answer any questions to the best of our ability. We will file your insurance claims for you as a courtesy.

☐ **Please be prepared to pay your estimated co-pay including any deductible due at the time of service.**

We will always give you an ***estimate*** of your out of pocket expenses, but **this is only an *estimate***.

☐ **You are responsible for any charges your insurance plan does not cover.**

☐ **Should your insurance company fail to pay your claim within 90 days, the remaining unpaid balance will automatically become your responsibility and will be due in full.**

Our office accepts Visa, MasterCard, Discover or cash as forms of payment. We also have financing available and will gladly discuss your options with you.

APPOINTMENT POLICIES

☐ **We require 3 business days' notice if you need to change your appointment to avoid a broken appointment fee or forfeit of your deposit.**

When scheduling your appointment, we are reserving and preparing a room **just** for *you*. Your records are prepared and special instruments are readied for your visit. We understand emergencies arise, but please be courteous and notify us. Repeated cancellations and/or broken appointments will result in loss of future appointment privileges

We also understand your time is valuable. Except for emergency treatment for another patient, you can expect us to be prompt.

I have thoroughly read and understand the above office policies and agree to these conditions.

Patient Signature _____ Date _____

425 North Wilson Road
Round Lake, IL 60073
RoundLakeFamilyDentistry@yahoo.com

Round Lake Family Dentistry

P: 847.740.0217
F: 847.740.0397

Welcome to Round Lake Family Dentistry – Please Tell Us About Yourself

Name: _____
Last First MI

Preferred Name: _____ ❑ Male ❑ Female SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

■ Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Group Number: _____ Group Name: _____

Insurance Company Name: _____

Insurance Company Phone: _____

■ Assignment and Release

I, the undersigned, certify that if I (or my dependent) have insurance coverage, we assign all insurance benefit payments directly to Round Lake Family Dentistry. I hereby give permission to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all services rendered in the absence of insurance coverage for treatment.

Responsible Party Signature : _____Date: _____

Relationship to Patient: _____

CONSENT FOR TREATMENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____ Date: _____

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MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑No
If yes, please explain: _____
Physician's Name: _____ Physician's Phone: _____
Have you ever had any major surgical procedures or even been hospitalized? ❑Yes ❑No
If yes, please list each one: _____
Have you had any artificial joints or joint replacement surgery? ❑Yes ❑No
If yes, please list each one: _____
Are you taking any medications? ❑Yes ❑No
If yes, please list each one: _____

Are you allergic to any of the following: (please check all that apply) **❑Aspirin ❑Penicillin ❑Codeine ❑Acrylic ❑Metal ❑Latex ❑Sulfa Drugs ❑Local Anesthetics ❑Other: _____**

Do you have, or have you had, any of the following? (please answer all)

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
❑	❑	AIDS/HIV Positive	❑	❑	Convulsions	❑	❑	Heart Pacemaker	❑	❑	Psychiatric Care
❑	❑	Alzheimer's Disease	❑	❑	Cortisone Medicine	❑	❑	Hemophilia	❑	❑	Radiation Treatments
❑	❑	Anaphylaxis	❑	❑	Diabetes	❑	❑	Hepatitis A	❑	❑	Recent Weight Loss
❑	❑	Anemia	❑	❑	Drug Addiction	❑	❑	Hepatitis B or C	❑	❑	Renal Dialysis
❑	❑	Angina /Chest Pain	❑	❑	Emphysema	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever
❑	❑	Arthritis / Gout	❑	❑	Epilepsy or Seizures	❑	❑	High Cholesterol	❑	❑	Rheumatism
❑	❑	Artificial Heart Valve	❑	❑	Excessive Bleeding	❑	❑	Hives or Rash	❑	❑	Scarlet Fever
❑	❑	Artificial Joint	❑	❑	Excessive Thirst	❑	❑	Hypoglycemia	❑	❑	Shingles
❑	❑	Asthma	❑	❑	Fainting	❑	❑	Irregular Heartbeat	❑	❑	Sickle Cell Disease
❑	❑	Blood Disease	❑	❑	Frequent Cough	❑	❑	Kidney Problems	❑	❑	Sinus Trouble
❑	❑	Blood Transfusion	❑	❑	Frequent Diarrhea	❑	❑	Liver Disease	❑	❑	Stomach Problems
❑	❑	Breathing Problems	❑	❑	Frequent Headaches	❑	❑	Low Blood Pressure	❑	❑	Stroke
❑	❑	Bruise Easily	❑	❑	Genital Herpes	❑	❑	Lung Disease	❑	❑	Swelling of Limbs
❑	❑	Cancer	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Disease
❑	❑	Chemotherapy	❑	❑	Hay Fever	❑	❑	Osteoporosis	❑	❑	Tonsillitis
❑	❑	Chest Pains	❑	❑	Heart Attack/Failure	❑	❑	Pain in Jaw Joints	❑	❑	Tuberculosis
❑	❑	Cold Sores	❑	❑	Heart Murmur	❑	❑	Parathyroid Disease	❑	❑	Ulcers

FEMALE PATIENTS - Please check all that apply – Are you currently:

❑ Currently Pregnant/Trying to get pregnant ❑ Nursing ❑ Taking Oral Contraceptives

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature _____ Date _____

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roundlakefamilydentistry@yahoo.com

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Please tell us more about your dental health…

How may we help you today? _____

Are you currently in pain? ❑ Yes ❑ No
If yes, please explain: _____

Do you like your smile? ❑ Yes ❑ No
Is there anything you would like to change about your smile? ❑ Yes ❑ No
If yes, please explain: _____

Are you happy with the color of your teeth? ❑ Yes ❑ No
Do your gums bleed? ❑ Yes ❑ No
How many times do you: Floss/week? _____ Brush/day? _____
Are your teeth sensitive to hot, cold, biting or anything else? ❑ Yes ❑ No
Have you ever been diagnosed with Sleep Apnea? ❑ Yes ❑ No
If Yes, Do you Wear a CPAP? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No **If Yes, Are you interested in replacing them?** ❑ Yes ❑ No
Do you grind or clench your teeth? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No
If yes, please explain: _____

When was your last dental checkup? _____

Why did you leave your previous dental office? _____

How can we better accommodate you during your dental visits? _____

Please circle any services below that you would like our staff to further discuss with you during your visit:

Teeth Whitening	Veneers/Lumineers	Invisalign – Clear Braces
Wisdom Teeth Removal	Smile Makeover	Bonding / Fillings
Crown or Bridge	Dental Implants	Partials/ Dentures
Night Guard	Snap-On Dentures	Sleep Apnea Appliance

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

Patient or Parent/Guardian Signature: _____

Date: _____

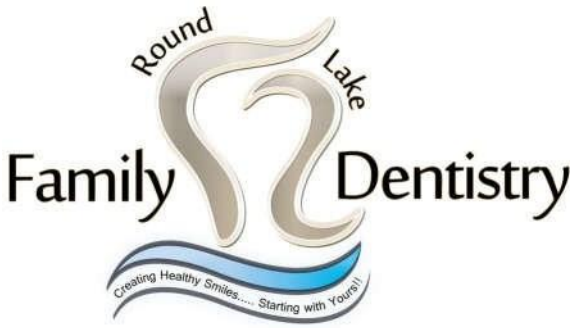
AUTHORIZATION TO RELEASE INFORMATION

I _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

Name: _____

Relationship: _____

Patient or Parent/Guardian Signature: _____



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 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 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 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 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 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. You may also request access by sending us a letter to the address 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 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.

Restrictions: 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: Dr. Kalpit Shah DDS **Tel. 847-740-0217** **Fax 847-740-0397**
Email: RoundLakeFamilyDentistry@gmail.com **Address: 425 N. Wilson Rd, Round Lake, IL 60073**