

WELCOME TO OUR PRACTICE!

CONFIDENTIAL

Thank you for selecting our dental healthcare team. Please fill out (please print) this form completely. If you have any questions or concerns, please ask our staff for assistance, we would be happy to help.

Patient Information

Name: _____ Birthdate: _____
Soc Sec. #: _____ Sex: ___ Male ___ Female Check Appropriate: ___ Minor ___ Single ___ Married ___ Other
Home Address: _____ Home Phone: _____ Cell Phone: _____
City: _____ State: _____ Zip Code: _____
Employer or School: _____ City: _____ State: _____ Phone: _____
Call Preference: ___ Home ___ Work ___ Either Spouse or Parents Name: _____
Person to Contact in Case of Emergency: _____

Whom May We Thank for Referring You?

Guarantor (If Other Than Patient)

Name: _____ Relationship: _____ Birthdate: _____
Address: _____ Phone: _____
Employer: _____ Work Phone: _____ Soc. Sec. #: _____

Insurance Information

Insurance Company Name: _____ Group #: _____
Claim Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____

Additional Insurance Information (Complete following for secondary Insurance)

Name of Insured: _____ Soc Sec. #: _____ Relationship: _____
Employer: _____ Phone: _____ Birthdate: _____
Insurance Company: _____ Group #: _____
Claim Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

Authorization and Release: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent if Minor) _____ **Date** _____

MEDICAL HISTORY

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Name: _____

Physician's Name: _____ City: _____ Date of last physical: _____
(MEDICAL)

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

(Circle One)	(Circle One)	(Circle One)
Heart MurmurYes No	AllergiesYes No	Respiratory DiseaseYes No
Mitral valve prolapseYes No	Sinus troubleYes No	AsthmaYes No
Artificial joint(s)Yes No	Blood diseaseYes No	EmphysemaYes No
Artificial heart valve(s)Yes No	Excessive bleedingYes No	TuberculosisYes No
Rheumatic feverYes No	CancerYes No	Thyroid problemsYes No
Heart trouble/diseaseYes No	X-ray treatment (radiation)Yes No	Hepatitis A (Infectious)Yes No
Angina/chest painYes No	DiabetesYes No	Hepatitis B (serum)Yes No
Heart pace makerYes No	Psychiatric careYes No	Hepatitis CYes No
Heart attack/failureYes No	Chronic depressionYes No	Cold soresYes No
High blood pressureYes No	StrokeYes No	Fever blistersYes No
	Epilepsy/seizuresYes No	HIV positiveYes No

Please give details of any of the conditions listed "yes" above: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Yes___ No___

If you have, please list drug/medication: _____

Have you ever had any other serious illness not listed above? Please discuss: _____

Are you taking any medication(s) at this time? If so, please list:

	Medication	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____

WOMEN:

Do you suspect that you are pregnant? Yes___ No___ If yes, when are you due? _____

Are you nursing? Yes___ No___ *Note: There are drugs and medications used in routine dental*

Are you taking birth control pills? Yes___ No___ *care that decrease the effectiveness of birth control.*

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about my current use of drugs and medication is essential. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____

DATE: _____

DENTAL HISTORY

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Welcome! So that we may provide you with the best possible dental care, please complete this dental history form. All information is completely confidential.

Name: _____ **Date:** _____

Previous dentist's name: _____ May we contact her/him Yes ___ No ___

City: _____

Date of last dental visit: _____ What was done? _____

Date of most recent full mouth x-rays (16-18 films): _____

Do you have any dental problems at this time? Yes ___ No ___

If yes, please describe: _____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? Yes No

If no, please explain: _____

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe: _____

ARE ANY OF YOUR TEETH SENSITIVE TO: (Circle One)

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters, or other oral lesions? Yes No

Do your gums ever bleed or hurt? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

HAVE YOU EVER HAD: (Circle One)

Periodontic treatment? (bones & gums)? Yes No

Your teeth ground or your bite adjusted? Yes No

A biteplane or a mouthguard? Yes No

A serious injury to your mouth or head? Yes No

If yes, please describe: _____

HAVE YOU EXPERIENCED: (Circle One)

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of the face, etc.): Yes No

Difficulty in opening or closing the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Sore muscles? (neck, shoulders, etc.) Yes No

Heavy snoring? Yes No

Clench or grind your teeth while awake/asleep? Yes No

Biting your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, fingernails, etc.) Yes No

Mouth breathing while asleep? Yes No

Tired jaws, especially in the morning? Yes No

Smoke / chew tobacco? Yes No
If yes, how much? _____

IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT YOU WOULD LIKE US TO KNOW?

Yes ___ No ___ If yes, please describe: _____

LANGFELD, CZAPLA & ASSOCIATES, D.D.S, P.C.

Phone 847-658-8508

Fax 847~669-8897

Douglas R Langefeld, D.D.S.

Marc E. Czapla, D.D.S.

Mark A. Matthaei, D.D.S.

4680 W, Algonquin Rd.

Lake in the Hills, IL 60156

FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered.

Dr.s Langefeld, Czapla & Associates, as a courtesy, we will be happy to file all insurance claims provided we have complete and updated insurance information. It remains the, patient responsibility to verify insurance benefits and preferred providers before the appointment.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance company and to insure your carrier remits payment promptly. If there is a problem with your claim it is your responsibility to act immediately to clear the problem with your insurance company.

Each month you will receive a statement explaining your outstanding bill. The statement will explain what is pending from your insurance company and/or the balance owed by patient. Patient balances are due and payable 30 days from the statement date. If there is a problem with your ability to pay your account, you are expected to contact the office to arrange a payment agreement.

If you have any questions concerning our policy or need assistance please feel free to contact our office.

I have read and agree to the above financial policy for the office of Langefeld, Czapla and Associates.

Signature _____ Date _____

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 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)

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 __/__/__, 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 credential 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._____ for each page, \$_____ 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: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____