Patient Registration

Patient Name: Last Name First Name Initial | Social Security #:

Address:	City:	State:	Zip Code:
Home #:( ) Work #:( )	Cell #:( )	Sex: ☐M ☐F	Date of Birth:
E-mail:	Employer/School:		

Who is responsible for this account?	Relationship to Patient:		
Address:	City:	State:	Zip Code:
Phone:( )	Social Security #:		

Emergency Contact:	Phone:( )	Relationship:

Whom may we thank for referring you?

Dental Information

Reason for today's visit:

Date of last dental care:	What was done at that time?	Date of last x-rays:

Medical History

Are you allergic to or have you had a reaction to:	Yes	No
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Iodine	☐	☐
Metals (specify):	☐	☐

Specify reaction for YES responses: ______________________

____

Have you had an orthopedic total joint replacement? ☐Y ☐N

When was the operation done?:______________________________

Any complications?:____

Has a physician recommended that you take antibiotics prior to your dental treatment? ☐Y ☐N

What was the antibiotic and the dose?______________________

Women Only

Are you or could you be pregnant? ☐Y ☐N

Nursing? ☐Y ☐N

Taking Birth Control? ☐Y ☐N

Please indicate if you have or have had any of the following conditions:

- ☐ Abnormal Bleeding
- ☐ AIDS or HIV infection
- ☐ Rheumatoid arthritis
- ☐ Asthma/Emphysema
- ☐ Cancer/Chemotherapy/ Radiation Therapy
- ☐ Chemical Dependency
- ☐ Diabetes, type:______
- ☐ Epilepsy/Seizure Disorder
- ☐ Fainting
- ☐ Heart Disease (specify below)
  - ☐ Artificial Heart Valves
  - ☐ Congenital Heart Defect
  - ☐ Heart Attack
  - ☐ High Blood Pressure
  - ☐ Low Blood Pressure
  - ☐ Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis/Jaundice/Liver disease
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Sexually Transmitted Disease
- ☐ Tobacco Use
- ☐ Tuberculosis

Is there anything else we should know about in your medical history?

Are you under a Physician's care? ☐Y ☐N For what Conditions:

Please list any medications you are taking at this time:

I certify that I have read and understand the above. I acknowledge that the above information is accurate and complete and is only for the use in my treatment, billing, and processing of insurance. I will not hold my dentist or any other member of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

X Date _

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

OFFICE USE ONLY

Medical History Updated: X ________ Date ________ X ________ Date ________

X ________ Date ________ X ________ Date ________

Dental Insurance Information

Please provide us with the following information:

Policyholder Name:	Relationship to Patient:
Policyholder Social Security# or Insurance ID#:	Policyholder Date of Birth:
Insurance Company Name and Address:	Employer or Group Name:
	Group Number:
Insurance Company Phone #:	

Signature on File

As a courtesy to our patients, we file your dental insurance. Please sign this form so that we may submit claims on your behalf.

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance not covered by my insurance benefits.
- I authorize the release of information required to process my dental claim.

X____

Patient/Parent or Guardian Signature Date

- I authorize and direct dental payments from my insurance company to be paid directly to Jack P. Horbal, DDS

X____

Subscriber Signature Date

Notice of Privacy Practices

I have received a copy of Dr. Horbal's Notice of Privacy Practices.

X____

Patient/Parent or Guardian Signature Date

Jack P Horbal, DDS | Kerstin E Horbal, DDS
6033 N Sheridan Road | Chicago, IL, 60660 | 773-275-0110 | www.horbaldds.com

Financial Policy

Thank you for choosing our office as your dental care provider. We are committed to providing you and your family the best available dental care. We realize that every person's financial situation is different. For this reason, we have designed this financial policy to provide a variety of payment options to help ensure that all your dental needs are met. We ask that all responsible parties read our financial policy, initial each section and sign the bottom for our records. A copy is available on our website.

<u>Payment Options</u>

____ Payments for all services are due at the time services are rendered. For your convenience, we offer several payment options:

1. Cash, check, or credit card (Visa, Master Card, Discover)
2. 6-month no interest and 24-month interest payment plans are available through Care Credit.

<u>Insurance</u>

As a courtesy to you, it is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill. As a responsible party please understand:

____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract; our relationship is with you, not the insurance company. We will facilitate claims processing by supplying factual information to the insurance company. However, we will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, or "usual and customary" charges.

____ 2. All charges are your responsibility whether your insurance company pays or not. If your insurance does not remit payment within 60 days, the balance will be due in full from you.

____ 3. If any payment is made directly to you for service billed by us, you recognize an obligation to promptly remit payment to us.

<u>Please Note</u>

_____Any treatment plan over $1000.00 requires a 50% deposit prior to commencement with the balance due at completion.

____ Please understand that returned checks will be assessed a fee.

____ Balances not paid in a timely manner may be subject to collection and collection fees. After such default and upon referral to a collection agency or attorney by us, you will be responsible for all costs, collection agency fees, and attorney fees.

_____We request the courtesy of 24-hour notification to cancel an appointment. A fee of $50 is charged to patients who miss or cancel with insufficient notice more than 3 times in a calendar year.

We understand that temporary financial problems may affect timely payment. If such problems do arise, we encourage you to contact us promptly so that we may assist you in keeping your account in good standing. If you have any questions or concerns, we are always available to discuss this policy with you. Feel free to contact us at: 773-275-0110.

I have read the financial policy. I understand and agree to its terms.

Signature: ____ Date: ______________

H I P A A P R I V A C Y F O R M 1

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.} We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 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.______ for each page, $______ per hour for staff time to 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: ____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).