PATIENT
NAME _____
Last First Initial

Date _____ Date of Birth _____ ☐ Male ☐ Female

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH
TO BE ADDRESSED _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: RES. _____ BUS. _____

EMAIL ADDRESS _____

PATIENT/PARENT EMPLOYED BY _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVERS LICENSE NO. _____

Method of Payment **Check** ☐ **Credit Card** ☐ **Cash** ☐

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL _____

_____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF
EMERGENCY NOT LIVING WITH YOU _____

_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE _____

PROGRAM OR POLICY _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

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 payor of my dental benefits may pay less then the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION

PATIENT'S NAME _____
Last First Initial Date of Birth

1 . Purpose of initial visit _____

2. Are you aware of a problem? _____

3. How long since your last dental visit? _____

4. What was done at that time? _____

5. Previous dentist's name _____

Address: _____ Tel.( ) _____

6. When was the last time your teeth were cleaned? _____

SELECT THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? Yes No
   How often: _____
8. Were dental x-rays taken? Yes No
9. Have you lost any teeth or have any teeth been removed? Yes No
   Why? _____
10. Have they been replaced? Yes No
11. How have they been replaced?
   a. Fixed bridge _____ Age _____
   b. Removable bridge _____ Age _____
   c. Denture _____ Age _____
12. Are you unhappy with the replacement? Yes No
   If yes, explain: _____
13. Would you like to know about permanent replacements? Yes No
14. Have you ever had any problems or complications with previous dental treatment? Yes No
   If yes, explain: _____
15. Do you clench or grind your teeth? Yes No
16. Does your jaw click or pop? Yes No
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? Yes No
18. Do you have frequent headaches, neckaches or shoulder aches? Yes No
19. Does food get caught in your teeth? Yes No
20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
21. Do your gums bleed or hurt? Yes No
   When? _____
22. How often do you brush your teeth? _____ When? _____
23. Do you use dental floss? Yes No
   How often? _____
24. Are any of your teeth loose, tipped, shifted or chipped? Yes No
25. Are you unhappy with the appearance of your teeth? Yes No
26. How do you feel about your teeth in general? _____
27. Do you feel your breath is offensive at times? Yes No
28. Have you ever had gum treatment or surgery? Yes No
   What? _____
   Where? _____
   When? _____
29. Have you had any orthodontic work? Yes No
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
31. Do you have any questions or concerns? Yes No

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

PATIENT NAME _____

Last First Initial Date of Birth

SELECT THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Physician's Name _____
   Address _____
2. Are you under a physician's care? Yes No
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? Yes No
   (If yes, please list medications on the back of this form.)
5. Do you routinely take health related substances? Yes No
6. Are you allergic to any medications or substances? Yes No
7. Do you have any other allergies? Yes No
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? Yes No
9. Are you sensitive to any metals or latex? Yes No
10. Are you pregnant or suspect you may be? Yes No
11. Do you use any birth control medications? Yes No
12. Have you ever been treated for or been told you might have heart disease? Yes No
13. Do you have a pacemaker or an artificial heart valve implant? Yes No
14. Have you ever had rheumatic fever? Yes No
15. Are you aware of any heart murmurs? Yes No
16. Do you have high or low blood pressure? Yes No
17. Have you ever had a serious illness or major surgery? Yes No
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? Yes No
19. Do you have inflammatory diseases, such as arthritis or rheumatism? Yes No
20. Do you have any artificial joints / prosthesis? Yes No
21. Do you have any blood disorders, such as anemia, leukemia, etc.? Yes No
22. Have you ever bleed excessively after being cut or injured? Yes No
23. Do you have any stomach problems? Yes No
24. Do you have any kidney problems? Yes No
25. Do you have any liver problems? Yes No
26. Are you diabetic? Yes No
27. Do you have asthma? Yes No
28. Do you have epilepsy or seizure disorders? Yes No
29. Do you or have you had a venereal disease? Yes No
30. Have you ever tested positive for HIV? Yes No
31. Do you have AIDS? Yes No
32. Have you had or do you test positive for hepatitis? Yes No
33. Do you or have you had T.B.? Yes No
34. Do you smoke, chew, use snuff or any other form of tobacco? Yes No
35. Do you consume alcoholic beverages? Yes No
36. Do you habitually use controlled substances? Yes No
37. Have you had psychiatric treatment? Yes No
38. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phen-termine (fen-phen), dexfenfluramine (redux), or other weight loss products? Yes No
39. Do you have any disease, condition, or problem not listed? Yes No
    If so, explain _____
40. Is there anything else we should know about your health that we have not covered in this form? _____
41. Would you like to speak to the Doctor privately about any problem? Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/ GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

MEDICAL HISTORY

About Financial Arrangements and Dental Insurance.

We are committed to providing you with the best possible dental care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered. We accept cash, check (with valid ID), Visa, MasterCard, American Express and Discover. Other payment options are available and are subject to approval by GE Capitol Consumer Card Co. Returned checks are subject to a fee of $25.00. Balances older than 30 days are subject to interest charges of 2.0 percent per month or 24 percent per year. Should patient default on the account and a collection service is retained, patient is responsible for the entire balance from Dr. Matsumoto's office and the entire collection fee, including, but not limited to, attorney fees and court costs.

In order for us to provide for your dental needs, your appointment time is specifically reserved for you. We, therefore, reserve the right to charge $50.00 for broken appointments and for appointments canceled with less than 48 hours and/or two full business days advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. In addition, we will be happy to help you to process your insurance claim form for your reimbursement. A completed and signed insurance form must accompany all requests at each visit. However, you must realize that:

- ⇒ Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- ⇒ Our fees are generally considered to fall within acceptable range by most companies and therefore are covered up to the maximum allowed as determined by the limitations of your insurance plan.
- ⇒ Some plan reimbursements are based on an arbitrary "schedule" of fees. These plans bear no relationship to the current standard and the cost of care in this area.
- ⇒ Not all services are a covered benefit in all insurance contracts. Some insurance plans arbitrarily select certain services that are not covered.

We must emphasize that as dental care providers, *our relationship is with you not your insurance company.* While the filing of your insurance claim is a courtesy we extend to our patients, *all charges are your responsibility from the date services were rendered*. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance and the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to call us. We are here to help you.

Signature _____ Date _____

Edward J. Matsumoto, DDS 5153 North Clark Street, Suite 208, Chicago Illinois 60640-6823 773 271-7176

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:____________________________ Signature________________________Date________

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.