Brett Blacher DDS

NEW PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Name_____

Address_____

City_____

State_____Zip_____

SS#_____

EMAIL_____

Birthdate_____

☐ Married ☐ Single ☐ Male ☐ Female

Whom may we thank for referring you?

_____

DENTAL INSURANCE

Policy Holder Name (Subscriber)

_____

SS#_____Birthdate_____

Insurance Company _____

Employer:_____

Group #_____ID#_____

Customer Service #_____

WOMEN

Are you pregnant? ☐ Yes ☐ No

Taking birth control? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

PHONE NUMBERS

Home(___)_____Work(___)_____EXT_____Cell(___)_____

IN CASE OF AN EMERGENCY , CONTACT

Name_____Relationship_____

Phone#_____Work#_____

MEDICATIONS

Please list any medications you are currently taking **INCLUDING** all over the counter medicines_____

_____

_____

_____

_____

_____

Do you require pre-medication prior to dental appointments?_____

_____

_____

Pharmacy Name_____

Pharmacy #_____

ALLERGIES or UNUSUAL REACTIONS

☐ Latex

☐ Penicillin

☐ Sulfa

☐ Local Anesthetic

☐ Codeine

☐ Metals

☐ Fluoride

☐ Other

_____

_____

_____

HEALTH HISTORY

	YES	NO
Any Heart Conditions	____	____

Angina , Chest Pain, Congestive heart failure, Coronary artery disease, heart attack, Infective Endocarditis, Rheumatic heart disease, Pacemaker, Heart valve shunt or stents, etc. **Please circle all that apply or explain**

._____

PLEASE CHECK ALL THAT APPLY

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatoid
- ☐ Artificial Joints
  When_____
  What joint_____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Diabetes-type I, type II
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice/Liver Disease
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Organ Transplant
- ☐ Radiation
- ☐ Respiratory Disease
- ☐ Sinus Trouble
- ☐ Smoker/Tobacco use
- ☐ Thyroid Problems
- ☐ Tuberculosis

Do you suffer from cold sores or canker sores? YES NO
Do you snore? YES NO Have you been diagnosed with Sleep Apnea? YES NO
Do you grind or clench? YES NO
Is there anything you would like to change about your smile? YES NO

To the best of my knowledge all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider (s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper healthcare and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize all insurance benefits be paid to Brett Blacher, DDS.

SIGNATURE_____ **DATE**_____
(Parent or guardian, if patient is a minor)

Brett Blacher DDS
Ph 630.916.0701
450 E. 22nd St. Suite 201 Lombard, Illinois 60148

OFFICE POLICY

We request and appreciate payment in full when treatment is rendered, for all patients without dental assisted benefits. For patients with dental assisted benefits, we request and appreciate payment for all deductibles and patient co-payment estimated portions when treatment is rendered. Sometimes a benefit provider that is a third-party administrator or self- funded organization does not follow the insurance guidelines to release payment within the 30 day standard. If this is the case with your benefit provider, we will take payment for all services rendered and ask you to collect from your benefit provider directly, which we will be happy to file for you.

We accept Visa, Master Card, Discover, personal checks, and cash as forms of payment. We also offer outside dental financing through Care Credit, if your needs are extensive. We reserve the right to obtain a credit report from the credit bureau for all services rendered in this office.

If you have dental assisted benefits, it is imperative that you provide us with a copy of your current benefit card or a signed form in order for us to accept direct payment from your provider.

*Your benefit provider is an agreement between **you** and **your** benefit provider. Therefore, we request that you call your carrier to check the status of your outstanding claims 30 days following treatment. If payment has not been received from your carrier with 60 days of treatment, we do require that the balance be paid immediately. We simply cannot function as a lending institution, and we appreciate your understanding regarding these finances.* ***Remember; Insurance does not mean FREE!!!***

A retainer fee of 50% is required for any treatment involving laboratory work. The remaining 50% will be collected at the final appointment less any assisted benefits. This allows the doctor to meet our financial obligations to complete your treatment.

*If you are unable to keep your commitment for an appointment, we request at least a 48-hour notification. Failure of notification will result in a charge of **$50** (to be paid in full prior to next appointment.) Please understand that when you schedule an appointment with us, we have reserved this time to see you and we will make every effort to do so in a timely fashion. Please be sure of your availability! In respecting your very valuable time we do not "overbook" to protect ourselves from last minute changes. Please respect our valuable time as we do yours.*

I understand that I am responsible and obligated to pay for my treatment regardless of dental assisted benefits. In the event that my account should become delinquent, (past 60 days) Dr. Blacher reserves the right to utilize a third party to collect any interest, attorney's fees, and/or court costs that may be incurred as a result of efforts to collect my balance.

Patient Signature_____ Date_____

BRETT A. BLACHER, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR 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 laws. 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 this 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 qualification 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 receive 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 Patients 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 references 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).

USES AND DISCLOSURES OF HEALTH INFORMATION

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 practically 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 $0.50 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 form, 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 operation 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 alternate 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 you have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with 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: Brett A. Blacher, D.D.S.
Telephone: 630-916-0701 Fax: 630-916-4647
E-mail: blacherdds@gmail.com
Address: 450 E. 22nd St. Suite 201
Lombard IL 60148

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment *

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

_____

Please Print Name

_____

Signature

_____

Date

Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (please specify)

_____