630-375-0099
dr.kanani@aurorabrightdental.com
AuroraBrightDental.com

Aurora Bright Dental.
2003 Montgomery Rd. #103
Aurora, IL 60504

Patient Information (Person being seen)

First Name: ____________ **Last Name**: ____________ **Middle Initial**: ____________

Nickname: ____________ **Salutation**: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Dr. [ ] Other:

Address: ____________ **City, State, Zip**: ____________

Phone (home): ____________ **Phone** (Cell): ____________ **Phone** (work): ____________

Email Address: ____________

Birth Date: ____________ ***SSN**: ____________

Sex: [ ] Male [ ] Female **Marital Status**: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Referral Source: [ ] Internet [ ] Insurance [ ] Mailing [ ] Sign [ ] Other [ ]Co-Worker (Name):____________
[ ] Friend (Name):____________ [ ] Family (Name):____________

Financial Responsible Party (Parent or Guardian present at initial visit) >>>>> Skip if Same as Above<<<<<

First Name: ____________ **Last Name**: ____________ **Middle Initial**: ____________

Address: ____________ **City, State, Zip**: ____________

Phone (home): ____________ **Phone** (Cell): ____________ **Phone** (work): ____________

Birth Date: ____________ ***SSN**: ____________

Primary Dental Insurance Information

Subscriber Name: ____________ Relationship to Patient: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber SSN: ____________ Subscriber DOB: ____________

Subscriber Employer: ____________ Insurance Co. Name: ____________

Group/Policy #: ____________ Insurance Co. Phone: ____________

Member ID: ____________ Insurance Co. Address: ____________

Secondary Dental Insurance Information

Subscriber Name: ____________ Relationship to Patient: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber SSN: ____________ Subscriber DOB: ____________

Subscriber Employer: ____________ Insurance Co. Name: ____________

Group/Policy #: ____________ Insurance Co. Phone: ____________

Member ID: ____________ Insurance Co. Address: ____________

Primary Medical Insurance Information

Subscriber Name: ____________ Relationship to Patient: [ ] Self [ ] Spouse [ ] Child [ ] Other

Subscriber SSN: ____________ Subscriber DOB: ____________

Subscriber Employer: ____________ Insurance Co. Name: ____________

Group/Policy #: ____________ Insurance Co. Phone: ____________

Member ID: ____________ Insurance Co. Address: ____________

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Medical History

Patient Name:____ Date of Birth: _________________________________

Date of last dental visit?_____________________ Purpose of visit? ____

Do you have any of the following allergies? [ ] Amoxicillin [ ] Penicillin [ ] Latex

List any other allergies: ____

Are you pregnant? [ ] Yes [ ] No (if yes, how many months?) ________________

List any medications you are currently taking:

____

Are you under the care of a physician? [ ] Yes [ ] No (if yes, what is physician's name?) ________________________________

Have you been told you require premedication prior to dental treatment? [ ] Yes [ ] No

Please check all that apply below:

☐ AIDS/HIV	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Artificial Joints	☐ Head Injuries	☐ Pregnancy	☐ Venereal Disease
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Joint/hip Replacement
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	☐ Heart Surgery
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ Mitral Valve Prolapse
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	☐ Stroke
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ Liver Disease
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	☐ Excessive Bleeding

Please describe any other conditions not listed above: ____

To the best of my knowledge, all the above information provided are true and correct. I will notify the doctors of any changes in my health at my next appointment without fail.

Patient/Legal Guardian Signature: **X**_______________________________________ **Date**: _________________________

Emergency Contact Information

Primary Name: ____________________ Phone: ______________________ Relationship: ______________________

Secondary Name: ____________________ Phone: ______________________ Relationship: ______________________

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Informed Consent

Patient Name:______________________________DOB: _____________

1. **PAYMENT IS DUE** on the day services are rendered unless prior financial arrangements have been made. Any discount or coupons are void unless payment is made on or before the day of service.
2. If I carry dental insurance I understand that all dental services rendered are charged directly to me and that **I AM PERSONALLY RESPONSIBLE FOR ALL DENTAL FEES**. My dental insurance claims will be submitted as a courtesy, however; **I MUST** pay my **ESTIMATED** portion of the bill on or before the day of service.
    - 2.1. I understand that Aurora Bright Dental receives a summary of my benefit coverage, and all treatment estimates are based on the summary received from my dental insurance provider. Dental Plan summaries do not include every detail of my benefits. I am **responsible** for understanding the details of my dental insurance plan.
    - 2.2. Services **NOT** estimated to be covered by my insurance are due at the time services are rendered.
        - 2.2.1. I understand I am responsible for the **FULL** office fee on any service that is not a benefit of my dental plan.
    - 2.3. I understand that my dental insurance is **NOT** a guarantee of payment.
        - 2.3.1. My dental benefits are **NOT** a guarantee and are determined **ONLY** once a claim has been submitted to my dental insurance.
    - 2.4. I understand I am responsible for any remaining balance after a claim is closed.
        - 2.4.1. I understand that my insurance may deny, apply alternate benefits or frequency limitations; to any dental claim submitted on my behalf once it is received.
        - 2.4.2. Aurora Bright Dental is not responsible for limitations, exclusions or determinations made by my dental insurance plan or plan consultants. **I accept that all treatment recommended by Aurora Bright dental is considered on ideal personal health and not my dental insurance plan.**
    - 2.5. I understand Aurora Bright Dental is **NOT** responsible for remaining balances as a result of my dental plan benefits.
3. If I chose **NOT** to pay my **ESTIMATED** patient portion at time of service and prefer to wait on insurance to pay, I am **RESPONSIBLE** for the total amount of services on the date they are performed.
4. A monthly service charge of 2% (24% APR), with a monthly minimum fee of $15.00; will be added to my account for balances over 30 days from the date payment is due.
5. To secure an appointment time, exceeding 1 hour, requires a **MINIMAL PREPAYMENT OF $100 or 20%** (of Patient out-of-pocket portion), whichever is greater.
    - 5.1. Appointments are reserved exclusively for me and a **MINIMUM 36 HOUR** notice is required if I am unable to make my appointment so that this time can be made available to other patients.
    - 5.2. Deposits on appointments canceled within 36 hours are **NON-REFUNDABLE**
    - 5.3. Deposit will be carried over to first rescheduled appointment.
    - 5.4. Deposit is **NON-REFUNDABLE** if patient chooses not to reschedule.
6. **"Broken Appointment Fee"** of $100 will be assessed for any appointment canceled within 36 hours, for appointments without a PREPAYMENT
    - 6.1. A "one time" courtesy will be extended for extenuating circumstances within a 12 month period
    - 6.2. Patients who demonstrate a history of 2 broken appointments within 36 hours, in a 12 month period; **may** be asked to provide a credit card to reserve any future appointments at the practices' discretion.

I agree to the financial and appointment terms for all of my dental treatment and consent to have my dental care performed by the Doctors, Hygienist and Assistants of Aurora Bright Dental. I understand I am responsible for all fees for the services that may be performed and all my questions will be answered and recommended treatment explained to me. A copy of Aurora Bright Dental Financial and Payment Options policy is available to me at any time and I have been offered a copy for my personal records.

Signature of Patient or Legal Guardian: ___________________________________ Date:________________________

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PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

My signature confirms that **I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).** I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers including, Medical and Dental insurance; for my health care services.
- Appointment Reminders:such as voicemail messages, postcards, email, text or letters. You must provide in writing not to receive reminders indicating which forms of communication you do not prefer.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete describing of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I, ______________________________________, have received a copy of the Notice of Privacy Practices for the office of Aurora Bright Dental.

If signing on behalf of patient please inform the office of your relationship to the patient: ______________________.

Signature of Patient or Legal Guardian: _____________________________________ Date:_________________________

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2017, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information
We use and disclose health information about you without authorization for the following purposes:
Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental and medical health plans containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You or Your Personal Representative: 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 your personal representative, but only if you agree that we may do so in writing.

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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.
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.
Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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, email, text or letters). <u>You must provide in writing not to receive reminders indicating which forms of communication you do not prefer.</u>

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. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you **$2.00** for each page, **$25.00** 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, health care 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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:

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E-mail: dr.kanani@aurorabrightdental.com