MEDICAL HISTORY

PATIENT NAME:_____ **BIRTH DATE:**_____

Are you currently under a physician's care?.....❍ Yes ❍ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation?.....❍ Yes ❍ No If yes, please explain:_____
Have you ever had a serious head or neck injury? .....❍ Yes ❍ No If yes, please explain:_____
Are you taking any medications? .....❍ Yes ❍ No If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other
medications containing bisphosphonates? .....❍ Yes ❍ No
Do you have trouble breathing through the nose? .....❍ Yes ❍ No
Do you use tobacco?.....❍ Yes ❍ No
Do you use controlled substances?.....❍ Yes ❍ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal
❍ Latex ❍ Sulfa drugs ❍ Local Anesthetics
❍ Other (please explain):_____

FOR WOMEN ONLY

Are you pregnant or trying to get pregnant?.....❍ Yes ❍ No
Are you taking oral contraceptives?.....❍ Yes ❍ No
Are you nursing?.....❍ Yes ❍ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive ❍ Yes ❍ No	Convulsions ❍ Yes ❍ No	Herpes ❍ Yes ❍ No	Psychiatric Care ❍ Yes ❍ No
Alzheimer's Disease ❍ Yes ❍ No	Depression ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No
Anaphylaxis ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Huntington's Disease ❍ Yes ❍ No	Recent Weight Loss ❍ Yes ❍ No
Anemia ❍ Yes ❍ No	Emphysema ❍ Yes ❍ No	Hypoglycemia ❍ Yes ❍ No	Renal Dialysis ❍ Yes ❍ No
Angina ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	Insomnia ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Excessive Bleeding ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Rheumatism ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No	Excessive Thirst ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Scarlet Fever ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Fainting Spells/Dizziness ❍ Yes ❍ No	Liver Disease ❍ Yes ❍ No	Shingles ❍ Yes ❍ No
Asthma ❍ Yes ❍ No	Frequent Ear Infections ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No	Sinus Trouble ❍ Yes ❍ No
Blood Disease ❍ Yes ❍ No	Frequent Headaches ❍ Yes ❍ No	Lung Disease ❍ Yes ❍ No	Spinal Bifida ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No	Gastroesophageal Reflux ❍ Yes ❍ No	Meniere's Disease ❍ Yes ❍ No	Stomach/Intestinal Disease ❍ Yes ❍ No
Breathing Problem ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Migraines ❍ Yes ❍ No	Stroke ❍ Yes ❍ No
Bruise Easily ❍ Yes ❍ No	Hay Fever ❍ Yes ❍ No	Mitral Valve Prolapse ❍ Yes ❍ No	Thyroid Disease ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Heart Attack/Failure ❍ Yes ❍ No	Multiple Sclerosis ❍ Yes ❍ No	Tonsillitis ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No	Heart Murmur ❍ Yes ❍ No	Muscle Spasm ❍ Yes ❍ No	Tuberculosis ❍ Yes ❍ No
Chest Pains ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Muscle Tremors/Fatigue ❍ Yes ❍ No	Tumors or Growths ❍ Yes ❍ No
Chronic Fatigue ❍ Yes ❍ No	Heart Trouble/Disease ❍ Yes ❍ No	Muscular Dystrophy ❍ Yes ❍ No	Ulcers ❍ Yes ❍ No
Cold Hands and Feet ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Osteoporosis ❍ Yes ❍ No	Veneral Disease ❍ Yes ❍ No
Cold Sores/Fever Blisters ❍ Yes ❍ No	Hepatitis A ❍ Yes ❍ No	Pain in Jaw Joints ❍ Yes ❍ No	
Congenital Heart Disorder ❍ Yes ❍ No	Hepatitis B or C ❍ Yes ❍ No	Parkinson's Disease ❍ Yes ❍ No	

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain:_____

COMMENTS: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient/Parent/Guardian Signature Date

Referred by:_____

ID: _____

Chart ID:_____

PATIENT REGISTRATION

Patient First Name:_____ **Last Name:** _____**MI:** _____

Patient is: ❍ **Policy Holder** ❍ **Responsible Party** **Preferred Name:**_____

Responsible Party (if someone other than the patient)

Last name: _____ First name: _____ MI:_____

Date of birth:_____ Driver's license number:_____

SSN: _____ Email address: _____

Home phone: _____ Cell: _____ Work Phone:_____

Address: _____

City: _____ State:_____ Zip:_____

❍ Responsible Party is also a Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Patient Information

Address: _____

City: _____ State:_____ Zip:_____

Home phone: _____ Cell: _____ Work Phone:_____

Sex: ____Male ____Female Marital Status: ____Married ____Single ____Divorced ____Separated ____Widowed

Birth Date: _____ Age:_____ Driver's license number:_____

SSN: _____ Email address: _____

Would you like to receive correspondence via email? ❍ Yes ❍ No

Medicaid ID: _____ Pref. Dentist:_____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID: _____ Pref. Hygenist:_____

Cell:_____

Email:_____

Emergency Contact

Name:_____

Phone:_____

Primary Insurance Information

Name of Insured:_____

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SSN:_____

Insured Date of Birth: _____

Employer: _____

Employer Address: _____

_____

Insurance Company: _____

Insurance Company Address: _____

_____

Rem. Benefits: _____:00 Rem. Deduct.:_____:00

Secondary Insurance Information

Name of Insured:_____

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SSN:_____

Insured Date of Birth: _____

Employer: _____

Employer Address: _____

_____

Insurance Company: _____

Insurance Company Address: _____

_____

Rem. Benefits: _____:00 Rem. Deduct.:_____:00

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 (MM/DD/YR), 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. !n 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 direcily 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).

NOTICE OF PRIVACY PRACTICES — CONTINUED

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 $.50 for each page, $30.00 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, healthcare operations and certain other activities, for the iast 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, costbased 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.

QUESTIONS AND COMPLAINTS BK DENTAL CONTACT OFFICER

Boris Kaltchev DMD
Email: staff@bkdental.com
Address: 140 E. Commercial Street, Wood Dale, Illinois 60191

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a Notice of Privacy Practice from the practice of Boris Kaltchev, DMD, P.C. and BK Dental LLC.

CONSENT FOR PHOTOGRAPHY

I, _____, hereby consent that photographs and x-rays taken of me by the practice of Boris Kaltchev, DMD, P.C. and BK Dental LLC may be used for any of the following purposes:

1. For inclusion in my dental record.
2. For any purpose of illustration, publication In dental or medical journals, or for any other dental purpose deemed appropriate by Boris Kaltchev, DMD, P.C.
3. For Boris Kaltchev, DMD, P.C. websites, office displays or brochures.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays. study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date_____

Parent/Responsible Party's Signature _____ Relationship to Patient_____

Witness_____

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Borislav Kaltchev, D.M.D., my dental-health care provider, to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all medical and dental health benefits due to me and my dependents.

I authorize payment to Boris Kaltchev, D.M.D. P.C. and BK Dental, LLC, the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

I also authorize Dr. Kaltchev, or his staff, to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays and photographs) about my medical/dental history, or about services rendered or treatment given to me or my dependents, that is needed to review, investigate or evaluate any claim or benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective while I am a patient of record of Boris Kaltchev, D.M.D., P.C. and BK Dental LLC.

A photocopy of this authorization may act as an original.

I know that I have a right to receive a copy of this Authorization and Acknowledgement if requested.

Signature of Patient or Insured_____ Today's Date_____