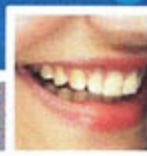
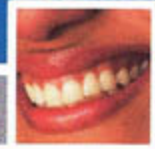
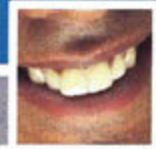
Esplanade Dental Care
2001 Butterfield Rd.
Suite 140
Downers Grove IL 60515
(630)493-0914

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper

☐ School ☐ Work ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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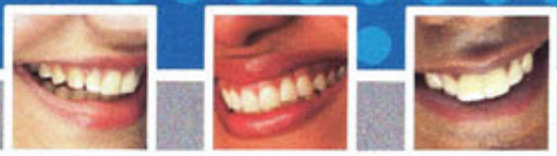

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

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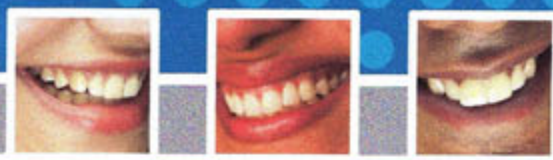

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Primary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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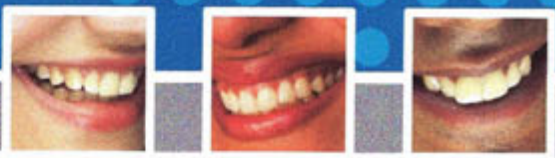

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

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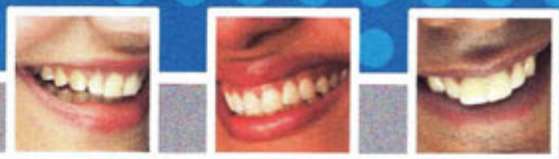

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Please indicate if you have experienced any of the following:

☐ *Pre-medicate	☐ Allergies	☐ Allergy Aspirin	☐ Allergy Codeine
☐ Allergy Erythromycin	☐ Allergy Latex	☐ Allergy Penicillin	☐ Allergy Sulfa
☐ Allergy Tetracycline	☐ Alleries Seasonal	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Birth Control	☐ Blood Disease
☐ Cancer	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Growths
☐ Hay Fever	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders
☐ Mitral Valve Prolaps	☐ Nervous Disorders	☐ Pacemaker	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ See Notes	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Thyroid	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease			

Do you have any other health issues or allergies?

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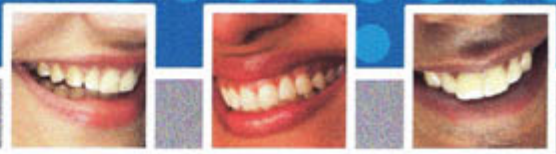

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

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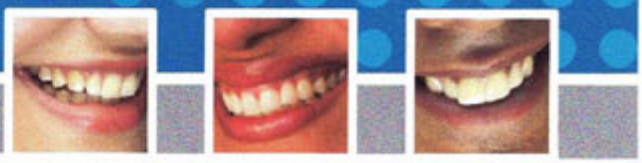

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date:

Relationship to Patient:

Response Date:

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception – dental insurance was NOT designed to pay for ALL dental care. Most contracts have limits/and or various degrees of co-payments. All deductibles and co-payments WILL be collected at the time treatment is started.

All levels of payment by insurance companies, including allowed fees, usual and customary, are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between you and your insurance company and that the patient bears the ultimate financial responsibility for any costs incurred for treatment.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing or insurance, and once again thank you for choosing Dr. Albert for your dental care.

Sincerely,

Dr. Sherif Albert
ESPLANADE DENTAL CARE

PLEASE INITIAL _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices has been created by Esplanade Dental Care ("Provider") to inform you of how we may use your protected health information for treatment, payment and health care operations purposes and as otherwise permitted by law. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with regard to accessing, amending and controlling the use of your protected health information.

We will abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice of Privacy Practices at any time as it applies to all unprotected health information in our custody without providing any notice of such change. Upon the occurrence of any revision of the terms of the Notice of Privacy Practices currently in effect, you may obtain a revised copy of this Notice of Privacy Practices from our registration personnel at our office located at 2001 Butterfield Road, Suite 140, Downers Grove, Illinois at your request.

The Privacy Contract for the Provider is; Sherif M. Albert, D.D.S., P.C. Please direct all questions and requests to the Privacy Contract in writing at the address listed in the preceding paragraph.

I. Treatment, Payment and Health Care Operations

Following are examples of some, but not all, of the types of uses and disclosures of your protected health care information that we are permitted to make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your protected health information, as necessary, to a hospital that provides care to you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We will disclose to your health insurance company information about the goods and services rendered to you in order to obtain payment from your insurance company. We may also disclose your protected health information to another entity so that it may seek payment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, face-to-face marketing activities, and conducting or arranging for other business activities.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information, as

necessary, to contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

We may disclose your protected health information to another entity for: health care fraud and abuse detection or compliance, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions that do not include treatment, reviewing the competence of health care professionals, conducting training programs, accreditation, certification, licensing, credentialing or other similar activities. Disclosures described in the preceding sentence will only be made if the other entity has or had a relationship with you.

We may disclose your protected health information to an organized health care arrangement in which we participate for any health care operation activities of said organized health care arrangement. An example of an organized health care arrangement is a hospital and its medical staff.

II. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization.

Other uses and disclosures of your protected health information for purposes other than treatment, payment and health care operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

III. Uses and Disclosures for Which You Have the Opportunity to Agree or Object.

We may use or disclose your protected health information in the circumstances described in this Section III, without seeking an authorization, provided we first give you an opportunity to object to such use or disclosure. If you are present, we may provide you with an opportunity to object and accept your failure to object as your agreement, or we may reasonably infer from the circumstances that you do not object. If you are not present or are unable to agree or object to such use or disclosure of your protected health information, we may use our professional judgment to determine whether the use or disclosure of your protected health information is in your best interest. All communications described in this Section III may be done orally. For example, unless you object, we may disclose your protected health information to your family member, other relative or close personal friend or any other individual identified by you as being a person who is directly involved with your care or payment relating to your care or treatment.

IV. Uses and Disclosures of Protected Health Information, Which Do Not Require Your Authorization or Opportunity to Object.

We are permitted under certain circumstances to make the following uses and disclosures of your protected health information without having to obtain your authorization, or give you an opportunity to object: uses and disclosures required by law; uses and disclosures for public health activities, such as reporting of disease, child abuse, injury, or vital events such as birth or death; disclosure to an employer if you are a member of the employer's workforce and we have been requested by the employer to conduct an evaluation relating to medical surveillance of the

The Right to an Accounting of the Disclosures of Protected Health Information. You have the right to an accounting of how we have disclosed your protected health information we have made in the six-year period prior to the date of your request for the accounting.

We are not required to account for uses and disclosures of your protected health information by us: to carry out treatment, payment or health care operations performed by us or our business associates; to other health care providers to provide treatment to you; to other covered entities or health care providers for payment activities of said persons; to other covered entities which have had a treatment relationship with you for certain health care operations purposes of said entities; to you pursuant to your rights to access your protected health information; made pursuant to an authorization signed by you; to friends and family involved in your care and treatment or payment for your care and treatment, or for certain notification purposes; for national security or intelligence purposes; to correctional authorities with respect to persons in custody; that occurred prior to April 14, 2003; or incident to a use or disclosure otherwise permitted or required by law.

Your request for an accounting must be made in writing to our Privacy Contact at 2001 Butterfield Road, Suite 140, Downers Grove, IL 60515.Your first request in any twelve (12) month period will be provided to you at no charge; however, additional requests will be charged to you based on our cost to conduct the accounting. We will inform you of the fee for the additional accountings prior to our conducting the accounting so that you may consider whether to modify or withdraw your request before you incur any fees.

Right to Receive Paper Notice. If you have agreed to receive this notice electronically, you have the right to receive a paper copy of this notice at our office at 2001 Butterfield Road, Suite 140, Downers Grove, IL 60515.

VI. Complaints.

If you believe your privacy rights have been violated or that we have not complied with this Notice of Privacy Practices, you may file a written complaint with our Privacy Contact at 2001 Butterfield Road, Suite 140, Downers Grove, IL 60515 or with the Secretary of the U.S. Department of Health and Human Services. Our Privacy Contact can also be reached by calling 630-493-0914. We will not penalize or charge you for filing a complaint with our Privacy Contact.

VII. Additional Rights; Effective Date.

This Notice of Privacy Practices has been prepared to reflect your rights under the Health Insurance Portability and Accountability Act. If state law provides you with greater access to information, or provides greater protection to that information, than as described in this policy, then we shall follow the provisions of state law. Examples of such state laws are the Mental Health and Developmental Disabilities Confidentiality Act, the AIDS Confidentiality Act and the Genetic Information Privacy Act. In addition, if a Federal law creates greater protection for the information described in this Policy, the Provider shall follow the provisions of such federal law. An example of such a Federal law is the Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970.

This Notice of Privacy Practices is effective as of April 7, 2003.

workplace or to evaluate whether you have a work-related illness or injury; disclosure to a governmental authority if we reasonably believe that you are a victim of abuse, neglect or domestic violence; disclosure to health oversight agencies (e.g., the U.S. Department of Health and Human Services) for oversight activities authorized by law; disclosures for legal proceedings; disclosures for law enforcement purposes; disclosures concerning decedents; uses and disclosures for cadaveric organ, eye or tissue donation purposes; uses and disclosures for research purposes; uses and disclosures to avert a serious threat to health or safety; disclosures regarding protected health information of members of the armed forces to appropriate military command authorities; national security and intelligence activities; disclosures to correctional authorities regarding protected health information of persons in custody; and disclosures as authorized to comply with workers' compensation laws.

V. **Your Rights**

The Right to Request Restriction of Uses and Disclosures. You have the right to request that we restrict the uses or disclosures of your protected health information to carry out treatment, payment or health care operations and to family members, other relatives or persons directly involved in your care or payment. We are not required to agree to any such restrictions, but if we do, we must comply with such restrictions, other than in an emergency or certain other circumstances permitted or required by law.

The Right to Confidential Communications. You have the right to submit a written request to our Privacy Contact that we provide you with an alternative means of communication in the event you tell us that our customary methods of communication may not preserve the confidentiality of your information. You may request that we send such communications to you to alternative locations. We will attempt to accommodate all reasonable requests.

The Right to Access Protected Health Information. You have a right to submit a written request to our Privacy Contact to inspect and copy your protected health information. Under certain circumstances, we may deny your request to inspect and copy your protected health information.

We may charge a fee for the cost of copying, postage or other items or services involved with your request. You may not remove our records from the premises.

The Right to Amend Protected Health Information. You have the right to submit a written request to our Privacy Contact that we amend your protected health information in our custody, and you must explain the basis for your request. We may deny your request to amend your protected health information if a) we did not create the information unless the individual or entity that created the information is no longer available to make the requested amendment, b) the information is not maintained by or in our custody, c) you do not have the right to access such information, or d) we have determined that such information is accurate and complete.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the **HIPPA** Notice of Privacy Practices.

_____
Print name of patient

_____ _____
Signature of patient or Date
Patient's representative

_____
Print name of person signing if different
than patient

_____
If person signing is a representative, describe
the basis for the patient's authority to sign
on behalf of patient.

Esplanade Dental Care

Sherif Albert, DDS, PC

Thank you for giving us the opportunity to help you achieve your dental goals. My staff and I will strive to deliver the type of service and atmosphere that you should expect from a superb dental office. To do this we ask for your help. We value your opinion and appreciate hearing about the things you like and about the things we could improve to better serve you.

The following policies were established to minimize expenses and enable us to better control fees:

Financial Policy:

1. If you have any questions about fees for planned treatment, please ask us because it is your right to have any questions answered.
2. We accept cash, checks, and major bank cards (MasterCard, Visa, and Discover).
3. Dental Insurance: We will file your insurance forms as a courtesy. Any balance above and beyond the estimate provided that is not paid by the insurance company will need to be paid at the time service is rendered.

Reservations:

Your reservation time has been reserved just for you. If you cannot keep your reservation, we ask that you kindly give us two business days notice so that we will be able to fill your time slot. Otherwise, our office policy is to charge a fee that covers expenses incurred by failed reservations. Exceptions are occasionally made, but are less likely the less notice we are given or the more often reservations are missed.

Photography:

Dr. Albert often takes photos to better explain certain aspects of your existing and/or planned treatment. We request your permission to show these photographs to better explain treatment options to other patients. These photos from time to time will also be used for continuing education purposes for other dentists.

My signature acknowledges that:

All questions have been answered truthfully and completely,
Photographs of me may be used for educational purposes as stated above,
I understand the office policy with keeping appointments, and
I understand and will comply with the office financial policy.
I give my consent for treatment.

PATIENT'S SIGNATURE DATE