herbert m. kanter, d.d.s.

buffalo grove oral and maxillofacial surgery, p.c.

Practice Limited to Oral and Maxillofacial Surgery

The following Confidential Information is for Our Records Only

(Please Print)

Rev.
Dr.
Mr.
Mrs.
Ms.
Miss.
(Please Circle)

Date: _____

Patient Name _____ Nickname _____

Age _____ Date of Birth _____

Home Address: Street _____ Apt. _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

Patient's Place of Employment _____

Business Address: Street _____ City _____ Zip _____

Patient's Social Security Number _____

Spouse/Parent Place of Employment _____ Phone (_____) _____

Business Address: Street _____ City _____ Zip _____

Spouse/Parent Social Security Number _____

Person to Pay Bill _____ Relationship _____

Address of Responsible Party _____ Signature _____

Dental Insurance: Insurance Company Name _____

Address _____

Phone Number (_____) _____

Group and ID# _____

Subscriber/Policy Holder's Name _____ DOB _____ SSN _____

Medical Insurance: Insurance Company Name _____

Address _____

Phone Number (_____) _____

Group and ID# _____

Subscriber/Policy Holder's Name _____ DOB _____ SSN _____

Referred by _____

Name of Dentist _____

Name of Physician _____

Have you ever been a patient in this office? _____ if so, when? _____

Who is to drive you home today? (General Anesthesia Only) _____

In case of emergency, please notify:

Name _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Relationship _____

Please complete medical history on the reverse side

Medical History Form

Patient's Name _____

	Check One	
	Yes	No
1. Have you had anything to eat or drink within the past 6 hours? (general anesthesia only)	☐	☐
2. Have you been hospitalized during the past 2 years?	☐	☐
3. Have you been under the care of a doctor (M.D.) during the past 2 years?	☐	☐
4. Are you allergic to penicillin or any other drugs, medicines or foods?	☐	☐
Please list _____		
5. Have you ever had any excessive bleeding requiring special treatment?	☐	☐
6. Do you use oral contraceptives? (women only)	☐	☐
7. Are you pregnant? (women only)	☐	☐
8. Are you wearing contact lenses?	☐	☐
9. Are you wearing a removable dental appliance?	☐	☐
10. Have you ever tested positive for H.I.V.?	☐	☐
11. If yes, do you have A.I.D.S.?	☐	☐

12. Check the name of any of the following which you have had:

☐ Stroke	☐ Diabetes
☐ Angina (Chest Pain)	☐ Asthma
☐ Heart Disease	☐ Tuberculosis
☐ Heart Murmur/Mitral Valve Prolapse	☐ Hepatitis
☐ Rheumatic Fever	☐ Jaundice
☐ High Blood Pressure	☐ Ulcers
☐ Arthritis	☐ Artificial Joints

Have you ever been treated for any disease or illness not listed above?
Please explain: _____

_____

If you are presently taking medication, please list:_____

_____

FEES AND PAYMENTS:
We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Payment arrangements can be made with our office manager depending upon special circumstances. If you have dental and/or medical insurance we will be glad to complete the proper forms. Please provide your current information to the receptionist.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me unless I intend to pay in full.

I hereby certify that the provided information is correct.

Signature: _____ Date: _____

Health History Reviewed . . . . . .Date: _____ Initial: _____

Buffalo Grove Oral and Maxillofacial Surgery, P.C.
Communication Policy Waiver

Communication is a very important part of providing quality health care. In an effort to provide you with timely information regarding your health care we ask that you complete this waiver.

Home Phone: ( ) _____
Work Phone: ( ) _____
Cell Phone: ( ) _____

We normally contact our patients between 9:00 a.m. and 5:00 p.m. Please provide the phone number that we should use to contact you during that time period.
Home Work Cell

If we need to reach you outside these hours, what is the phone number that we should use to contact you?
Home Work Cell

If you are unavailable at the time we contact you, may we leave medical information with another person? Yes No
If yes, who_____
(For example, discuss test results with spouse; disclose diagnosis with lab or pharmacy)

Leave medical information on voice mail or answering machine? Yes No

Recently enacted Federal Laws protecting a patient's privacy prevent us from sharing any information about your medical condition without your authorization. If you would like us to release information to another treating physician, please authorize or decline by signing below.

_____ _____
(AUTHORIZE) Signature Date

_____ _____
(DECLINE) Signature Witness

NOTICE OF PRIVACY PRACTICES

HERBERT M. KANTER, D.D.S.
3325 N. ARLINGTON HEIGHTS RD.
SUITE 600A
ARLINGTON HEIGHTS, IL 60004
(847) 259-8883

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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 respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about **HIPAA** or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775