

Millennium Park Dentistry
Richard J. Johnson, D.D.S. P.C.
55 East Washington Street
Suite 2905
Chicago, Illinois 60602
(312) 782-0694
RJohnson@MPDDS.com

*WELCOME! PLEASE FILL IN THE FOLLOWING CONFIDENTIAL FORM
COMPLETELY PLEASE ANSWER ALL QUESTIONS. PLEASE USE YOUR KEYBOARD
AND MOUSE TO COMPLETE THE FORM AND THEN PRINT IT, SIGN IT AND
EITHER MAIL IT, FAX IT OR BRING IT WITH YOU TO YOUR FIRST APPOINTMENT*

PATIENT NAME _____ DATE OF BIRTH _____
(Last) (First) (Initial)
ADDRESS _____ MARITAL STATUS _____
(City) (State) (Zip) SPOUSE'S NAME _____
HOME PHONE _____
SOCIAL SECURITY NUMBER _____ EMAIL ADDRESS _____
PARENT'S NAME (IF CHILD) _____

EMPLOYER
NAME _____ HOW LONG _____
ADDRESS _____ PHONE _____
(City) (State) (Zip)

DENTAL INSURANCE

PRIMARY	SECONDARY (IF APPLICABLE)
INSURED'S NAME _____	_____
CARRIER NAME _____	_____
GROUP NUMBER _____	_____
SOCIAL SECURITY or ID NUMBER _____	_____

EMERGENCY CONTACT (LOCAL)
NAME _____
DAYTIME PHONE NUMBER _____

REFERRED BY
NAME _____
ADDRESS _____
(City) (State) (zip)
PHONE NUMBER _____

Due to the increased cost of mailing statements and in trying to keep our fees as low as possible, we find it necessary to expect our patients to pay for services at the time services are rendered. All fees are your responsibility. We will be happy to submit dental claims for you with the insurance payment going directly to you. We want to give you the best and most reasonable service possible without having to raise our fees. We appreciate your cooperation in this matter. We are happy to answer any questions you may have.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICY.

PATIENT SIGNATURE

DATE

Richard J. Johnson, D.D.S. P.C.
 55 East Washington Street
 Suite 2905
 Chicago, Illinois 60602
 (312) 782-0694

FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT, PLEASE FILL IN THE FOLLOWING CONFIDENTIAL FORM COMPLETELY PLEASE ANSWER ALL QUESTIONS.

Name: _____ Date _____
 (Please Print)

MEDICAL INFORMATION

	Yes	No
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the last year?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an orthopedic joint replacement (hip, knee, elbow, finger)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was this operation done? _____		
If yes, have you had any complications or difficulties with the prosthetic joint?	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____		
Are you taking or have you recently taken any medicine/medicines including non-prescription medicine/medicines?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medicine/medicines are you taking? _____		
Have you been told by your physician that you need to pre-medicate prior to any dental appointment?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for what reason? _____		
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently use tobacco (smoking, snuff, chew)?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to:			Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetics (local)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type 1)	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type 11)	<input type="checkbox"/>	<input type="checkbox"/>	replacement	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify) _____			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizzy	<input type="checkbox"/>	<input type="checkbox"/>	Phenphen	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	GE Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Severe/rapid weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____			Persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Date _____			Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers or sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			
Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	HIV infection	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, please specify _____								

Do you have any disease, condition or problem not listed above that you think I should know about? If yes, please specify

WOMEN ONLY:

	Yes	No
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>

Physician Name: _____

Address: _____

Phone: _____

What is the reason for your visit today? _____

Date of dental last visit? _____

What was done at your last visit? _____

Previous dentist's name _____

Address _____ City _____ State _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss? _____ Yes No

Do you have any dental problems now?

If yes, please describe _____

Are any of your teeth sensitive to:

Hot or cold? Sweets?

Biting or chewing?

Have you noticed any mouth odors or bad tastes?

Do you frequently get cold sores, blisters or any other oral lesions?

Do your gums bleed or hurt?

Does food tend to become caught in between your teeth?

If yes, where? _____

Do you: Clench or grind your teeth while awake or asleep?

Mouth breathe while awake or asleep?

Have tired jaws, especially in the morning?

Have you ever had: Orthodontic treatment? Oral surgery? Periodontal treatment?

Have you ever experienced: Clicking or popping of the jaw?

Pain (joint, ear, side of face)?

Difficulty in opening or closing the mouth?

Difficulty in chewing on either side of the mouth?

Headaches, neck aches or shoulder aches?

Are you satisfied with your teeth's appearance?

Would you like to, keep all of your teeth all of your life?

Do you feel nervous about having dental treatment?

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know?

Millennium Park Dentistry
Richard J. Johnson, D.D.S., P.C.

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 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 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. 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 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 officials 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).

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. (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).

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 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 Communications: You have the right to request, in writing, that we communicate with you about your health information by alternative means or to alternative locations. 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. Our dental office will accommodate your request, if the request is reasonable and in writing.

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.

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.

Office Contact: Betty Jayko

Telephone: (312) 782-0694 Fax: (312) 236-1456

Address: 55 East Washington Street
Suite 2905
Chicago, Illinois 60602

Millennium Park Dentistry
Richard J. Johnson, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement
Lab

I, _____ ,

PLEASE TYPE OR PRINT YOUR NAME

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

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
