Dokhanchi Dental Services, DDS, PC
DBA Fox Valley Dental Care Aurora
2424 W Indian Trail, Unit E
Aurora, IL 60506

Please fill out all the fields. We are a paperless office and after entering your information into our computers, all documents will be shredded. We will never sell your private information.

Patient Information

First Name	Last Name	Middle Initial
Address		Apartment
City	State	Zip Code
Cell Phone	Home Phone	Work Phone
Birth Date	Social Security Number	Drivers Lic.
Sex: ☐ M ☐ F	☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Partnered	
Email (For our use only)		Can we text you? ☐Yes ☐ No
Employer	Employer Address	
Occupation	Whom may we thank for referring you?	
Person subscribed with Insurance/Responsible for Account		Relation to Patient
Subscriber Birth Date	Subscriber ID/ Social Security	

Insurance Information (you can skip this segment if you have given us your **current** insurance cards)

Insurance Name	Address
Insurance Phone Number	Group Number

Do you have additional insurance? ☐Yes ☐No If Yes please fill out the following:

Secondary Insurance Name	Address
Insurance Phone Number	Group Number

Subscriber Name	Birth Date	Subscriber ID/ Social Security

Please Complete Other Side

INSTRUCTIONS

I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission.

Dental History

Date of last cleaning and x-rays	Former Dentist and Location

Reason for Today's Visit or any dental complaints

Medical History

Do you have any allergies: ☐None

☐Penicillin ☐Latex ☐Ibuprofen ☐Sulfa Drugs **Any Other allergies?**

Please list all your medications you currently take:

Are you pregnant or breast feeding? ☐Yes ☐No Your Physician's name and Number:

Please check the box if you have or have had any of the following:

☐Anemia	☐Excessive Bleeding	☐Prostate Disease
☐Arthritis, Rheumatism	☐Fainting	☐Psychiatric Disorders
☐Artificial Heart Valve	☐Glaucoma	☐Radiation Treatment
☐Artificial Joints	☐Head Injuries	☐Respiratory Problems
☐Asthma	☐Headaches	☐Rheumatic Fever
☐Back Problems	☐Heart Disease	☐Scarlet Fever
☐Blood Disease/Transfusion	☐Heart Murmur	☐Shortness of Breath
☐Cancer	☐Hemophilia	☐Sinus Problems
☐Chemical Dependency	☐Hepatitis	☐Stomach Problems
☐Chemotherapy	☐High Blood Pressure	☐Stroke
☐Circulatory Problems	☐High Cholesterol	☐Swelling Feet/Ankles
☐Cortisone Treatment	☐HIV/AIDS	☐Swollen Glands
☐Cough-Persistent	☐IV Bisphosphonate Treatment	☐Thyroids Problems
☐Cough up Blood	☐Kidney Disease	☐Tobacco Habit
☐Dental treatment complication	☐Liver Disease	☐Tuberculosis
☐Diabetes	☐Lung Disease	☐Tumors
☐DVT/Clotting Problem	☐Multiple Sclerosis	☐Ulcers
☐Epilepsy	☐Pacemaker	☐Venereal Disease

Please list any illness or operations you have had <u>that are not listed above</u>:

Authorization: I certify that I, and/or my dependents, have insurance coverage and assign directly to Dokhanchi Dental Services, DDS,PC all insurance benefits otherwise payable to me for services rendered. <u>I understand that I am financially responsible for all charges whether or not paid by Insurance.</u> I authorize the use of my signature on all insurance submissions. Dokhanchi Dental Services may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits. This consent is valid as long as I am a patient at Dokhanchi Dental Services, PC.

Signature of Patient, Parent, or Guardian _____ Date_____

If Parent or Guardian Please Print Name_____ Relation to Patient_____

Dokhanchi Dental Services, DDS, PC
DBA Fox Valley Dental Care
243 E. Indian Trail
Aurora, IL 60505

Our Financial Policy

Payment in full is expected when services are rendered unless previous arrangements have been made with our patient coordinator. If you have dental insurance, we will gladly file the necessary paperwork for you and wait to be paid by your insurance company. However, your co-payment is due at the time services are rendered. If your insurance fails to pay for services performed for you in a timely manner, you are responsible for the full fee. Co-payments calculated at out office are only an estimate since the actual fees paid by insurance may differ.

If your insurance coverage changes or is terminated, it is your responsibility to inform us. If we are no longer a participating provider as a result of this change, you will be responsible for all fees at the time services are rendered. If your insurance denies benefit for any reason, we will appeal on your behalf. However, you are ultimately responsible for all fees for services rendered. By signing below you will give us permission to file claims with your insurance company and get reimbursed directly by them.

Accounts over 90 days old incur a $10.00 per month rebilling charge. If no arrangements are made with our patient coordinator, accounts over 90 days may incur a $15 service fee and be placed with our collection department.

Our Cancellation Policy

Unlike some offices, we do not double or triple book our schedule. Your appointment time is only reserved for you. Consistent with most healthcare facilities, we require a **48-hour** notice for any cancellation or changes to your appointment or you maybe charged $50 per 30 minute appointment. In case of rare emergencies, please discuss the matter with our office coordinator.

Emailing your X-rays Options

At times, we may need to transfer your X-rays to another dentist or a specialist. Emailing them is a convenient and faster way of transferring them. Please note that there is a risk an unauthorized person may intercept this email and view your X-Rays. **We remove your name and any other identifiable information from the X-rays**. Please check an option below:

___I give permission to email my X-rays
___I will pick up and hand deliver X-rays

Patient Name:_____ Date:_____

Signature of patient or legal guardian:_____

Please Complete Other Side

Fox Valley Dental Care
243 E. Indian Trail
Aurora, IL 60505

Notice of Privacy Practices Acknowledgement (HIPPA Notice)

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in treatment directly or indirectly.
2- Obtain Payment from third-party payers
3- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy.

Patient Name	Relation to Patient

Date	Signature

For Office Use

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)_____