Submit by Email | Print Form

Instructions

Please fill out the form as completely as possible. When you're done, you have two choices. Click the button below to either:

1) Click the "Submit by Email" button and send this document to our office; or
2) Print the form and bring it with you to your appointment

Smiling Patient Dental Care
Dr. Bianca Malin & Dr. Mayya Bakman
322 N. Wolf Rd Mt. Prospect, IL 60056
847.824.5151 office 847.824.8981 fax
www.smilingpatient.com

Welcome

Submit by Email | Print Form | Reset Form

Patient Information

SSN _____ Current Date 1/3/15

First Name _____ Initial ____ Last Name _____

Address _____

City _____ State ____ Zip Code _____

Sex _____ Marital Status _____ Birthday _____

Occupation _____

Employer _____

Contact Information

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:
(Specify someone who does not live in your household)

Name _____

Home Phone _____

Relationship _____

Questionnaire

Whom may we thank for referring you?

What is important to you when choosing your new dentist?

Are you satisfied with your tooth appearance?	Yes	No
Are you satisfied with your tooth color?	Yes	No
Do you feel your teeth are crowded?	Yes	No
Do you feel your teeth are poorly aligned?	Yes	No
Do you feel your teeth are protruding?	Yes	No
Do you suffer from dental decay in your front teeth?	Yes	No
Do you have non-esthetic front teeth restorations?	Yes	No
Do you have fractures in your front teeth?	Yes	No
Are you hiding your teeth while smiling?	Yes	No

Dental Insurance

Relationship to Patient? _____

Insurance Company _____

Subscriber's Name _____

Subscriber's Birthday _____ SSN _____

Group # _____

Medications

List any medications you are currently taking and the correlating diagnosis:

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Skin reaction to jewelry
- ☐ Any known metal allergies
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (Specify)

Dental History

Reason for Today's Visit

Former Dentist

City/State

Date/Last Visit

Date/Last Dental X-Rays

Please select "Yes" or "No" to indicate if you have had any of the following:

Bad breath	◯ Yes ◯ No	
Bleeding Gums	◯ Yes ◯ No	
Blisters on Lips or Mouth	◯ Yes ◯ No	
Burning sensation on tongue	◯ Yes ◯ No	
Chew on one side of mouth	◯ Yes ◯ No	
Smoking or Tobacco use	◯ Yes ◯ No	
Clicking or popping jaw	◯ Yes ◯ No	
Dry mouth	◯ Yes ◯ No	
Fingernail biting	◯ Yes ◯ No	
Food collection between teeth	◯ Yes ◯ No	
Grinding Teeth	◯ Yes ◯ No	
Loose teeth or broken fillings	◯ Yes ◯ No	
Mouth breathing	◯ Yes ◯ No	
Mouth pain, brushing	◯ Yes ◯ No	
Orthodontic treatment	◯ Yes ◯ No	
Pain around ear	◯ Yes ◯ No	
Periodontal treatment	◯ Yes ◯ No	
Sensitivity to cold	◯ Yes ◯ No	
Sensitivity to heat	◯ Yes ◯ No	
Sensitivity to sweets	◯ Yes ◯ No	
Sensitivity when biting	◯ Yes ◯ No	
Sores or growths in your mouth	◯ Yes ◯ No	

How often do you brush? _____

How often do you floss? _____

Health History

Physician's Name _____ City/State _____ Date/Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine?) ◯ Yes ◯ No

Please select "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Arthritis, Rheumatism	◯ Yes ◯ No	Fainting or dizziness	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No
Artificial Heart Valves	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Artificial Joints	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Shortness of breath	◯ Yes ◯ No
Back Problems	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No
Bleeding abnormally, with extractions or surgery	◯ Yes ◯ No	Hepatitis Type ____	◯ Yes ◯ No	Skin rash	◯ Yes ◯ No
		Herpes	◯ Yes ◯ No	Special diet	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Swollen feet or ankles	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	Jaw Pain	◯ Yes ◯ No	Swollen neck glands	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Thyroid problems	◯ Yes ◯ No
Circulatory Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Congenital Heart Lesions	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cortisone Treatments	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tumor or growth on head or neck	◯ Yes ◯ No
Cough, persistent or bloody	◯ Yes ◯ No	Nervous Problems	◯ Yes ◯ No	Ulcer	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Weight loss, unexplained	◯ Yes ◯ No
Do you wear contact lenses?	◯ Yes ◯ No				

Women Only:

Are you pregnant? ◯ Yes ◯ No Due date _____

Are you nursing? ◯ Yes ◯ No

Taking birth control pills? ◯ Yes ◯ No

SMILING PATIENT DENTAL CARE
THE SMILE STUDIO

FINANCIAL AGREEMENT
Bianca Malin DDS & Mayya Bakman DDS

We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients' financial capabilities.

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several convenient payment options:

Cash or Check

5% pre-payment discount for full payment of today's procedures

Note: $30 penalty for returned checks

Credit Card

Visa
MasterCard
Discover

Half up front, Half before completion

For your convenience
$500 minimum purchase

0% CareCredit Financing

For qualified applicants
$500 minimum purchase

Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly, therefore, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.

Please be aware that we will always review your proposed treatment and answer any questions related to your personal financial responsibility and insurance benefits. **We must emphasize that as dental care providers, our relationship is with you, not with your insurance company.** Please be aware that:

- Your insurance contract is between you, your employer, and the insurance company. **We are not a party to that contract.**
- Our fees are considered to fall within the acceptable range by most companies and therefore, are covered to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (Such as 50% or 80%) of the "U.R.C." defined as usual, reasonable, and customary fees for this region. However, we cannot guarantee that our fees will always fall within this range.
- **Not all services are a covered benefit in all contracts.** Some employers and insurance companies arbitrarily select particular services that are not covered by their benefit plan.

SMILINGPATIENT.COM
322 N. WOLF ROAD
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We encourage you to read your insurance policy so you are fully aware of the benefits and any limitations that were negotiated by your employer with your insurance company.

Please acknowledge your understanding of the following by signing below:

- **Payment is due at the time services are rendered.**
- As a courtesy service to you, **we will submit your insurance claim for your direct reimbursement** using the fastest means available.
- **Cash, Check, Visa, MasterCard, and Discover Card** are always welcome.
- For your convenience, we offer financing and/or payment plan options through Capitol One and CareCredit, which provides an **array of financing options, including interest-free payments for comprehensive treatment plans**. Inquire for details.
- **Returned checks are subject to a $30 returned check fee.**
- **Cancellations require 24 hour notice. Appointments canceled within 24 hours will be charged a $50 missed appointment fee.**
- **No show appointments will be charged a $50 missed appointment fee.**
- Outstanding balances **older than 60 days are subject to an interest charge of 1.5% per month.**
- **Outstanding balances older than 120 days may be relinquished to a collection agency.**

Please feel free to contact us with any questions. We are here to help you.

Thank you for your commitment to our practice. We look forward to seeing your smile and working together to provide a caring and comfortable environment for your optimal oral health care.

Print Name: _____

Signature: _____ **Date:** _____

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Print Form

SMILING PATIENT DENTAL CARE
THE SMILE STUDIO

Office of Dr. Bianca Malin & Dr. Mayya Bakman

Notice of Privacy Practices Acknowledgement

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

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in treatment directly and indirectly.
- Obtain Payment from third-party payers.
- Conduct normal health care 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 that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care questions. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so even though the Notice of Privacy Practices was received as documented below:

Date _____ Initials _____ Reason _____

www.SMILINGPATIENT.COM

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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 **April 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.

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.

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, e-mail or letters). You may opt out of appointment reminders.

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 a $20 handling fee, $0.75/page for pages 1-25; $0.50/page for pages 26-50; and $0.25/page for each page 51+. 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 last 6 years, but not before April 14, 2003.

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.

Contact Officer: **Bianca Malin, DDS**
Telephone: **(847) 824-5151**
Fax: **(847) 824-8981**
E-mail: **office@smilingpatient.com**
Address: **322 N Wolf Rd, Mt. Prospect, IL 60056**