Here at Windy City Smiles we value your time. In an effort to make your first visit the best expirence possible, we have placed all of our new patient forms in one location.
Please fill out the forms, print, and bring with you on you first visit. We look forward to serving all your dental needs!

WINDY CITY SMILES

{NAME OF PRACTICE}

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 4 / 01 / 2023, 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 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, 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 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 $0.25 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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. 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 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: Windy City Smiles

Telephone: 773-588-7645 Fax: _____

E-mail: info@windycitysmiles.com

Address: 3521 North Elston
Chicago, IL 60618

Windy City Smiles

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____

Please Print Name

_____

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)

_____

_____

_____

Windy City Smiles

www.windycitysmiles.com
3521 N. Elston Ave. • Chicago, IL 60618 (773)588-7645

Medical & Dental History Form

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◉ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Occupation

Height, & Weight

Emergency contact (Name & Phone number)

Referred by:

Please take a moment to let us know about your history so we may serve you more effectively. During your initial visit you will be asked some question about your responses and there may be additional questions concerning your health.

1. Would you consider yourself to be in good health? ○ Yes ○ No

2. Has there been any change in you general health within the past year? ○ Yes ○ No

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

4. Are you now under the care of a physician? ◯ Yes ◯ No

If yes, what is the condition being treated?

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

6. Have you had any serious illness, operation. or been hospitalized in the past 5 years? ◯ Yes ◯ No

If yes, what was the illness or problem?

7. Are you taking any medicine(s) including non-prescription medicine? ◯ Yes ◯ No

If yes, what medicine(s) are you taking?

Please indicate if you have experienced any of the following diseases or problems:

☐ *Pre-Med	☐ Allergies	☐ Allergy, Asprin	☐ Allergy, Codeine
☐ Allergy, Latex	☐ Allergy, Penicillin	☐ Allergy, Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Heart Val	☐ Artificial Joints	☐ Asthma or Hay fever
☐ Blood Disease	☐ Bronnchitis	☐ Cancer	☐ Coumidin Treatment
☐ Diabetes	☐ Dizziness	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Fainting Spells	☐ Glaucoma
☐ Growths	☐ HIV or AIDS	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ Immune Sys. Disorder
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorders	☐ Nervous Disorders	☐ Neurological Desease	☐ Pacemaker
☐ Persistent Diarrhea	☐ Persistent cough	☐ Pregnancy	☐ Radiation Treatment
☐ Recent weight loss	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ S.T.D.'s	☐ Seizures	☐ Sinus Problems	☐ Stomach Problems
☐ Stomach Ulcers	☐ Stroke	☐ Swollen joints	☐ Swollen neck glands
☐ Thyroid Problems	☐ Tuberculosis	☐ Tumors	☐ Venereal Disease

8. Do you have or have you had any of the following diseases or problems?

8 a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease. ◯ Yes ◯ No

8 b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke).
◯ Yes ◯ No

8 b1. Do you have chest pain upon exertion? ◯ Yes ◯ No

8 b2. Are you ever short of breath after mild exercise or when lying down? ◯ Yes ◯ No

8 b3. Do your ankles swell? ◯ Yes ◯ No

8 b4. Do you have inborn heart defects? ◯ Yes ◯ No

9. Have you had abnormal bleeding? ◯ Yes ◯ No

9 a. Have you ever required a blood transfusion? ◯ Yes ◯ No

10. Have you ever had any treatment for a tumor or growth? ◯ Yes ◯ No

11. Are you allergic or have you had a reaction to the following:

11 a. Local anesthetics ◯ Yes ◯ No

11 b. Penicillin or other antibiotics ◯ Yes ◯ No

11 c. Barbituates, sedatives, or sleeping pills ◯ Yes ◯ No

11 d. Iodine ◯ Yes ◯ No

11 e. Codeine or other narcotics ◯ Yes ◯ No

11 f. Other

_____

_____

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

_____

_____

13. Are you wearing contact lenses? ◯ Yes ◯ No

14. What is the date (or approximate date) of your last dental exam?

_____

_____

15. Have you had any serious trouble associated with any previous dental treatment? If yes, please explian

_____

_____

16. Are you wearing removable dental appliances? ◯ Yes ◯ No

17. What is the reason for your dental visit today?

_____

_____

WOMEN ONLY:

18. Are you pregnant? ◯ Yes ◯ No

19. Do you have any problems associated with your menstrual period? ◯ Yes ◯ No

20. Are you nursing? ◯ Yes ◯ No

21. Are you taking birth control pills? ◯ Yes ◯ No

Authorization

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.
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. Such information may be used in research, education, publication in professional journals, and or for any other use you deem appropriate

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____

Windy City Smiles SM
FRANCES R. CAVERO, DDS
Setting the standard for advanced preventive, cosmetic & orthodontic care
3521 N Elston Ave - Chicago, IL 60618 - 773.588.SMILE (7645)

Financial Policy

This is an agreement between Windy City Smiles, as creditor and the Patient/Debtor named on this from.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payment credited. The word "we", "us", and "our" refer to Windy City Smiles.

By executing this agreement, you are agreeing to pay for all the services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Payments are due at time of service, unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have no insurance:

1. You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance due before delivery.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
4. We offer special financing through Care Credit. If you pay them within 3 months, there will be no interest charges, or up to 72 months with interest.

Payment options if you have insurance:

(Please remember you are responsible for the full balance of your treatment, up until we receive insurance payment. Then you are responsible for any balances remaining.)

1. You must pay your deductible and any out-of-pocket portions at the time services are rendered by cash, credit card, , or Chase Quick Pay/Zelle.
2. You choose to pay all of your treatment by cash, credit card, , or Chase Quick Pay/Zelle. We will as a courtesy to you, at no extra charge, request your insurance carrier send payment directly to you.
3. On extensive treatment (crowns, bridges, Implants, etc.) you may pay 50% of your out-of-pocket portion on the start or preparation date, and the balance due before delivery date. (Normally two weeks.)
4. For visits under $200.00, payment is expected at the time of service, regardless of insurance. We will, at no extra charge, request your insurance carrier send their payment directly to you.

The Financial Policy continues on the back side of this page.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Financial Policy continued on other side

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by the insurance. If your insurance company requires a referral and/or preauthorization you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or the separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent, therefore it is the authorizing parent that is responsible for the account.

Finance Charge: A finance charge will be imposed on each item of your account, which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of two percent (2%) per month or an **ANNUAL PERCENT RATE** of twenty four (24%) percent. The finance charge on your account is computed by applying the periodic rate (2%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Past Due Accounts: A late fee will be applied, and if your account remains past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all the court cost. In case of suit, you agree the venue shall be in Cook County, Illinois.

Returned Checks: There is a fee (currently $50.00) for any checks returned by the bank.

No Show / Late Cancel Appointment:
The second time a patient does not show up on time for an appointment, or cancels with less than 48 hours notice, a $100.00 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with recurrent missed appointments will be asked to transfer their records to another doctor.

Credit History: You give us permission to check your credit and employment history and to answer any questions we may have, about your credit experience. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transferring Records: You will need to request in writing, pay a reasonable copying fees, and pay any unpaid balances due, if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferring from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to you initial visit. In addition to this verification, we require that you allow us to bill your insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient/Debtor's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Picture, Photographs, X-Rays and Film Release: I hereby give my authorization and release all pictures, photographs, X-rays, films and any other records in your possession. Such information may be used in research, education, publication in professional journals, and /or for any other use you deem appropriate.

Co-signature: If this or another Financial Policy is signed be another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect

Windy City Smiles SM
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3521 N Elston Ave - Chicago, IL 60618 - 773.588.SMILE (7645)

No Show/Late Cancel Policy for Appointments

1. **No Show/Late Cancel Policy for Appointments**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full' appointment book.

Cancellations with less than 48 business hours notice will be marked as a **"no show"**. Please call by 6:00 p.m. on Tuesday to cancel a Thursday appointment. After a second "no show" appointment, a credit card will be required to secure all future appointments.

After the second "no show" you will be charged One hundred dollars ($100.00) fee; this fee is not covered by your insurance.

2. **Late Arrivals for Scheduled Appointments**

We understand delays can happen, however, we must try to keep the other patients and the doctor on time. If you arrive 15 minutes or more past your scheduled time, you may or may not be seen at the discretion of management.

If you are not seen by the doctor due to tardiness on your behalf, you will be charged One hundred dollars ($100.00) fee; this is not covered by your insurance company.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Guardian Signature Date

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Photographs, X-Ray and Film Release

To: ***W**indy **C**ity **S**miles*℠

Patient Name: _____
Please Print

Re: Photograph, X-Ray and Film Release

I hereby give my authorization to make and or release all photographs, x-rays, videos and any other records in your possession. Such materials may be used or disclosed for research, educational purposes using various media formats including, but not limited to publication in professional journals, study clubs, website, social media format, youtube, etc., and or for any other use you deem appropriate.

I certify that I have read and fully understand this document.

Patient Signature: _____

Date: _____

Witness Name: _____
Please Print

Witness Signature: _____