

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

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ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS#: _____

Home Address: _____
Apt/Condo # _____
City State Zip

Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: ___ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Dentist Phone #: (____) _____ Last Visit Date: _____

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SPOUSE INFORMATION

His / Her Name: _____

Wk #: (____) _____ Ext: ___ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible For Account: _____
Apt/Condo # _____

Wk #: (____) _____ Ext: ___ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

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INSURANCE

Primary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

Address: _____

City State Zip

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

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MEDICAL HISTORY CONTINUED

Your current physical health is: Good Fair Poor
 Do you smoke or use tobacco in any other form? Yes No
 Have you had any metal rods, pins or implants? Yes No
 Are you taking any prescription / over-the-counter or herbal supplement drugs?
 Yes No

Please list each one: _____

For Women: Are you using a prescribed method of birth control?
 Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems

Y N Abnormal Bleeding / Hemophilia	Y N Herpes / Fever Blisters
Y N Alcohol / Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N Hospitalized for Any Reason
Y N Arthritis	Y N Kidney Problems
Y N Artificial Bones / Joints / Valves	Y N Liver Disease
Y N Asthma	Y N Low Blood Pressure
Y N Blood Transfusion	Y N Lupus
Y N Cancer / Chemotherapy	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic / Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease / Traits
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Heart Attack / Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Anything you would like to discuss with the dentist in private? Yes No

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry / Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs/materials that you are allergic to: _____

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DENTAL HISTORY

Why have you come to the dentist today? _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Y N Do your gums ever bleed? Y N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Hard Medium Soft

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? Yes No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

Payment is due in full at the time of treatment

Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____ Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

Signature _____ Date _____

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

Signature _____ Date _____



Family Roots DENTISTRY

FINANCIAL POLICY

Thank you for choosing us for all your dental needs. We are committed to providing you with the highest quality of care, and we offer a variety of convenient financial options to help you receive the dental care that you need and deserve. The following information is to inform you of our financial policy.

APPOINTMENTS / CANCELLATIONS

Your scheduled appointment is a time that we have reserved exclusively for you. We have various methods of reminding you of upcoming appointments.

We understand that there may be times when you are unable to keep your scheduled appointment. We kindly ask that you provide at least 2 business days notice if you need to cancel or reschedule your appointment. This allows us to offer the reserved time to another patient in need of care.

Appointments that are changed (cancelled or rescheduled) or missed with less than 2 business days notice will be subject to a **\$75 cancellation fee per appointment that was scheduled.**

Patients with repeated missed appointments or late cancellations may be subject to additional scheduling restrictions. The office reserves the right to limit or decline future scheduling, including requiring same-day scheduling or prepayment to reserve an appointment time. Our goal is to ensure fair access to care for all patients and to keep our schedule running efficiently so we can provide timely, high-quality dental care to everyone we serve.

INSURANCE

Dental insurance is incredibly complex, because each insurance policy has its own unique rules and stipulations that can vary greatly and can be hard to understand. If you have dental insurance, our knowledgeable team will help you understand your specific insurance plan to maximize your available benefits. We are also happy to file all paperwork and claims on your behalf.

Please keep in mind that your insurance policy is a specific contract between you and your insurance company. We are not a party to that contract and cannot guarantee coverage or benefits. We do our very best to collect all the information that we can from your insurance company prior to you receiving dental care so that we can provide you with the most accurate estimates of your coverage. We kindly request that you notify our office prior to your appointment of any changes in your dental insurance policy. If the information provided is incorrect, you will be responsible for payment.



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PAYMENT OPTIONS

We accept the following methods of payment: cash, check, and credit card (VISA, MasterCard, and Discover). Please note: There is a \$50 fee for all returned checks. We extend pre-payment courtesies as well as offer payment plans. We have also partnered with third-party companies for extended payment options.

Your expected payment is due in full at the time of service unless prior arrangements have been made. We communicate all recommended treatment options and associated fees prior to the start of treatment.

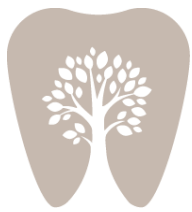
MINORS

For parents or guardians of minors, the parent or guardian that accompanies the minor to their visit assumes financial responsibility for the minor's account. I understand the above information and agree to its contents.

Signature: _____

Date: _____

(Patient/responsible party)



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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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **9/23/2013** 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as related to HIV, genetic, alcohol &/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involving your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include

quality assessment and improvement activities, conducting training programs and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair or replacement of products or devices;



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-Notify a person who may have been exposed to a disease or condition; or
-Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

National Security. We may disclose to military authorities the 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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Dept. of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process instituted by someone else in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out.

Other Uses & Disclosures of PHI.

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided in this Notice (or as otherwise permitted by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to view or get copies of your PHI, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies



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mailed to you. Contact us for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your PHI, you must submit in writing to the Privacy Official. If you request this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests.

Right to Request a Restriction. You have the right to request additional restriction on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this notice electronically on our Website or by e-mail.

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, if you disagree with a decision we made about access to your PHI 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 locations, you may send a complaint to us using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file this complaint 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 for the U.S. Dept. of Health and Human Services.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Effective Date: February 16, 2026

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Family Roots Dentistry
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Address: 4811 W. Crystal Lake Road, McHenry, IL 60050
E-mail: Office@FamilyRootsDentistry.com



Family Roots DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please note: you may refuse to sign this acknowledgement.

I have received, read, and understand this office's Notice of Privacy Practices.

Signature _____ Date: _____

FOR OFFICE USE ONLY

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

_____ Individual refused to sign

_____ Communications barriers prevented obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other

If other, please specify:

Date _____



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Multimedia Release Form

I _____, authorize the doctors and/or any of the assignees of Family Roots Dentistry to take photographs, slides, and videos of my teeth, jaws, and/or face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used primarily for communication with other health care professionals as it relates to my care.

The content may also be used for educational publications (dental journals), educational lectures, and/or advertising purposes (including website publication, Facebook posts, etc.). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (portrait photos, first name only) could be used. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

I understand that audio recordings may be used during the visit for clinical purposes only. These recordings help ensure accurate and thorough documentation of my care. All recordings are kept confidential and handled in accordance with applicable privacy laws and regulations. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____ I agree for my media to be used in any of the above stated situations

_____ I agree for my media to be used in any of the above stated situations, but only without identifying features (mouth/teeth only).

_____ I do not consent for any of my media to be used publicly. I consent for my media to be used only used as a record of my care and for communication with other health care professionals as it relates to my patient care.

Signed _____ Date _____