

On behalf of my staff and I, we welcome you to our family of fine patients. Thank you for selecting me as your personal dentist. We look forward to seeing you.

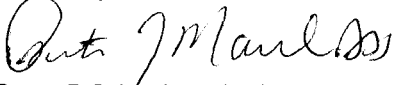
You, our patients, are the most important part of our practice. It is our goal to be able to render to you the best and most up-to-date treatment available today and in years to come. We want to make your time with us a pleasant experience. We will sincerely try to earn your trust and confidence, so that you may feel comfortable in referring your family and friends to our office.

Concerning your dental treatment, whatever is recommended for you is based on what I would recommend for a member of my own family under similar circumstances.

Before your visit, would you please take a few minutes to fill out the enclosed patient registration and health history. Bring the completed form with you, as this will streamline your first visit. For an adult, we reserve a full hour for your x-rays and a thorough exam. A cleaning is not done at the first visit for an adult.

Thank you for selecting me as your personal dentist, and again, we welcome you to our family of fine patients.

Sincerely,

  
Peter J. March, D.D.S.

# PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

What name do you prefer we use when we address you? \_\_\_\_\_

Spouse's name \_\_\_\_\_

**Home Phone # ( \_\_\_\_\_ )** \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

E-Mail address \_\_\_\_\_

Street address \_\_\_\_\_

P.O. Box # \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Length of time at this address: \_\_\_\_\_

If less than 2 years: please list previous address:

Street address \_\_\_\_\_

P.O. Box # \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Male/Female? \_\_\_\_\_

Married/Single/Divorced/Widowed? \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Please list other family members who are patients at our office:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person to contact for emergency:

Name \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

For Office Use:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birth date \_\_\_\_\_

Street address \_\_\_\_\_

P.O. Box # \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's work phone ( \_\_\_\_\_ ) \_\_\_\_\_

## DENTAL INSURANCE

**Primary Carrier**

Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_

Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Date Employed \_\_\_\_\_

Group # \_\_\_\_\_

**Secondary Carrier**

Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_

Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Date Employed \_\_\_\_\_

Group # \_\_\_\_\_

**PLEASE TURN OVER TO COMPLETE**

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs or pills? ..... YES NO

If yes, please list: \_\_\_\_\_

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO
- If yes, please list: \_\_\_\_\_

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Stroke	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Kidney Trouble	YES	NO	Veneral Disease	YES	NO
Congenital Heart Disease	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Pain in Jaw Joints	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
  9. Do your ankles swell during the day? ..... YES NO
  10. Do you use more than two pillows to sleep? ..... YES NO
  11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
  12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
  13. Are you on a special diet? ..... YES NO
  14. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
  15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
- If yes, please list: \_\_\_\_\_

**FOR WOMEN ONLY:**

Are you pregnant?  Yes, what month? \_\_\_\_\_  No Are you nursing?  Yes  No Are you taking birth control pills?  Yes  No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT:**

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) \_\_\_\_\_

and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



**Comprehensive and Cosmetic Dentistry for Your Family**

**Peter J. March, D.D.S.**

517 S. Governors Highway, Peotone, Illinois 60468  
Telephone: (708) 258-6281 • Fax (708) 258-6981

Dear Patients,

Enclosed is a notice of our office privacy guidelines. This notice and your acknowledgement that you have received the notice is a requirement under a new federal guideline. Be assured that the confidentiality of our patient's health records has always been a priority in our office. In fact, our previous efforts to protect our patient's records more than satisfy these new guidelines.

Please have all adult members who are patients at our office review the enclosed notice of privacy practices. We are required to ask you to complete the acknowledgement of receipt of this notice on the back of this letter. Please bring it to our office at your next visit.

We will be happy to answer any questions you may have. We can be reached at 708-258-6281. Thank you and we look forward to continuing to provide the highest quality dental services to all of our patients.

Sincerely,

A handwritten signature in cursive script that reads 'Peter J. March D.D.S.'.

Peter J. March D.D.S.

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Peter J. March, D.D.S., P.C.

NOTICE OF PRIVACY PRACTICES

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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.

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**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 13, 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.

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**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.

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**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).

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#### **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 \$0.50 for each page 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.

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#### **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: Peter J. March, D.D.S.

Telephone: 708-258-6281 Fax: 708-258-6981

Address: 517 S. Governors Highway Peotone, IL 60468

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**Peter J. March , D.D.S., P.C.**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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

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Please Print Your Name & the names of any minors or dependants

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Signature

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Date

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We welcome you to our practice. We are committed to providing you with excellent service. As part of this service, the following is a statement of payment options we offer for your treatment. So that you will be well-informed, we ask that you read the following options and sign below prior to any treatment.

1. Payment in full is requested for routine treatment, up to \$300.00, at the time of your visit. We accept cash, check, Visa or Mastercard. To clarify the increasingly common question of who is financially responsible for the child of divorced or separated parents, in our office, the adult who the child lives with is held financially responsible. We will gladly supply duplicate statements for the other parent.

2. As a courtesy to you, we do accept insurance and will submit insurance claims for you. Having insurance is a wonderful benefit, which usually provides partial payment of your treatment. Please be aware that your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract, so we have little control over the benefits which you will receive and any unpaid balance remains your responsibility. To help you maximize your benefits, we ask that you bring your insurance booklet for us to review and a completed claim form. If you do not have a booklet, please call your insurance company before your visit to find out your benefits, deductible and yearly maximum.

We will bill your insurance for payment, and accept assignment of benefits pending a review of your credit history. Please be prepared to pay your copayment percentage and any deductible at the time of your visit. Payment in full is expected in 30 days and interest charges will accrue after that time. Please contact your insurance on any unpaid claims, as often much quicker payment results when the patient inquires about payment.

If you like, you may pay your balance in full, we will submit your insurance claim and have the insurance company reimburse you directly. This often results in much quicker payment by the insurance company and you will not have to worry about any interest charges accruing.

3. To help you choose ideal dental care, after a review of your credit history, we may offer you the following options for more extensive treatment where your balance would be more than \$300.00:

- A. You may pay 50% at the beginning of treatment and 50% at the completion of treatment.
- B. You may fill out an application for a dental charge card, and when you are approved, this plan offers zero percent interest for balances of \$300 minimum for up to 6 months and \$500 minimum for 12 months.

We look forward to discussing the above options with you and helping you decide which will work best for your dental health. Please check below whether you may require financing if your out-of-pocket fees exceed \$300. Also, please sign below signifying that you have read this information and agree to abide by one of the payment options described above. Thank you.

\_\_\_\_\_ I may request financing if my treatment fees exceed \$300.

\_\_\_\_\_ I will not request financing if my treatment fees exceed \$300.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME (PLEASE PRINT)