

# WELCOME TO GALAXY DENTAL

We would like to take this opportunity to welcome and thank you for joining our dental practice. We appreciate your confidence in us and we will do everything possible to provide you with finest dental care. Please take a few minutes to answer the following questions so we can assist you with your dental needs. The better we communicate, the better we can care for you.

## PATIENT REGISTRATION



ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is: ☐ Policy Holder Preferred Name: \_\_\_\_\_  
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

### —Patient Information—

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_ ☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

### Section 3

Referred By: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

### —Primary Insurance Information—

Name of Insured: \_\_\_\_\_ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

### —Secondary Insurance Information—

Name of Insured: \_\_\_\_\_ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No \_\_\_\_\_

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin    ☐ Penicillin    ☐ Codeine    ☐ Acrylic    ☐ Metal    ☐ Latex    ☐ Local Anesthetics    ☐ Sulfa Drugs  
☐ Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
|   |  |  |  | <input type="checkbox"/> Venereal Disease           |
|   |  |  |  | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## 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 in this Notice. We may charge you a reasonable cost based fee for expenses such as staff time, copies and postage if you want them mailed to you. You may also request access by sending us a letter to the address in this Notice. 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 in 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.

**Restrictions:** You have the right to request that we place additional restrictions on our use of 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.



## 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 this Notice about our privacy practices, and 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 04/14/03, 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 in this Notice.

## 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 of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights 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 the Privacy Officer or with the Office for Civil Rights.

**Privacy Officer:** Igor T. of Galaxy Dental

Telephone: (847) 306-9336 Fax: (847) 305-1222

Address: Privacy@galaxy-dental.com  
1532 Lake Cook Rd  
Wheeling, IL 60090

### Office for Civil Rights

U.S. Department of Health and Human Services  
61 Forsyth Street, SW. - Suite 3B70  
Atlanta, GA 30323  
(404) 562-7886; (404) 331-2867 (TDD)  
(404) 562-7881 FAX

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14, 2002. Subsequent law changes may require Form revision.



## **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 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 of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 or 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).



1532 East Lake Cook Rd  
Wheeling, IL 60090  
847-306-9336

## **Appointment Policy**

- If you have All Kids Copay, it will apply to every visit.
- If you have Insurance Co-pay, it will apply to every visit.
- All **EMERGENCY** must be scheduled on weekdays **before 4 PM.**
- Please note that the time of your appointment was specifically reserved for you. If you are unable to make your appointment, at least 24-hour notice is required.

**\$50 fee will be assessed for broken appointments.**

- The possibility of a failed appointment is considered if arrival is 15 minutes late.
- Reminder calls, text messages and e-mails are courtesy to our patients but it is patient's responsibility to keep track of the appointment dates and to notify us of any changes.
- We reserve the right to terminate your dental work treatment if you miss more than two, or are chronically late to your appointments.

### **Additional charges**

- There will also be an added service charge of **\$25** for handling any returned checks.
- **Past due** accounts will be submitted to an agency that will try to collect past due amounts. All costs incurred for the collection of past due accounts, including reasonable attorney's fees will be passed on to you.

Date \_\_\_\_\_

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

Signature of patient, parent or guardian \_\_\_\_\_



## **Insurance Coverage**

***While we check your insurance benefits as a courtesy, we want you to know that it is your responsibility to know and check your insurance benefits, as you are ultimately responsible for payment on your account, even when you are using insurance benefits. Use of insurance benefits is reflective of a contract between you and your insurer, and use of insurance benefits is not a guarantee of claims authorization, processing, or payment, even if your insurer has verified your benefits or authorized services up front. We cannot be responsible for inaccurate information provided to you or our practice by your insurer.***

- ***Insurance Change has to be provided to us 24 hours before scheduled visit.***
- ***Proof of active insurance policy must be presented on a day of the visit.***
- ***Insurance claims submitted on the day of service only and cannot be submitted on an any other date.***

☐

***I DO NOT HAVE A DENTAL INSURANCE COVERAGE***

☐

***I am Covered by a Dental Insurance and will  
provide my insurance information***

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Patient Signature:** \_\_\_\_\_



## ***HIPAA Acknowledgement***

***By my signature I acknowledge that I have read and understand the Hipaa Notice of Privacy Practice of Dr Zhana Krasnyuk.***

***Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_***

***Patient or Parent Signature : \_\_\_\_\_***