Dr.Jeffrey Kinka, DMD | 2704 N Halsted St. Chicago, IL 60614 | 773-348-2704

NEW PATIENT REGISTRATION

Date: _____

Name: _____ SS#: _____

Address: _____Apt #:_____

City: _____ State: _____ Zip Code: _____

Cell: _____ Date of Birth: _____

Sex at Birth: _____ Gender: _____ Pronoun(s): _____

Would you like to receive confirmations/correspondence via email? _____ Yes _____ No

If so, please provide your email address: _____

Patient employed by: _____ Occupation: _____

Whom may we thank for referring you? _____

Primary Dental Insurance

Policy Holder: _____ Birthday: _____

Member ID# or Social Security #: _____

Employed by: _____ Group Number: _____

Insurance Company: _____
Address of Insurance: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____

Text (773) 348-2704 or Email dentalmasterslp@gmail.com a photo or copy of insurance card front and back

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Dental History

Reason for today's visit _____

Date of last dental care _____ Date of last dental x-ray _____

How often do you brush? _____ When do you floss? _____

Check if you have had any of the following:

___ Cold Sores of Fever Blisters
___ Sensitive or Painful Teeth
___ Bad Breath (Halitosis)
___ Dry Mouth (Xerostomia)
___ Bleed Gums
___ Gum Surgery
___ "Deep Cleaning"
___ Periodontal Treatment
___ Jaw Pain
___ Clicking/Popping Jaw
___ Grinding of Teeth (Bruxism)
___ Clenching of Teeth
___ Pain in or about your ears
___ Frequent Headaches
___ Migraines
___ Neck-aches
___ Braces/Orthodontic Treatment
___ Loose Fillings
___ Broken Teeth/Fillings
___ Pain upon chewing/biting
___ Sensitivity to sweets
___ Food packs between teeth
___ Dental Implants
___ Wisdom Teeth Extraction

- Do you snore? _____
- Are you apprehensive or nervous about dental treatment? _____
- Would you be interested in sedation or "sleep" dentistry? _____
- Do you feel you have a healthy mouth? _____
- Do you like your smile? _____
- Would you like whiter teeth? _____
- Would you like straighter teeth? _____
- Do you avoid certain foods due to missing teeth or pain upon chewing? _____
- If you have missing teeth, would you like them replaced? _____
- What did you like most about previous dental experiences? _____
- Why did you leave your previous dentist? _____
- Is there anything we can do to make your visits more comfortable? _____

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

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	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

COVID-19

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:

X Date:_____

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Office Policies

Broken/Canceled Appointments: We are very appreciative of patients who arrive on time for their scheduled appointments. In the unlikely event you need to cancel an appointment, we request notice at least 72 hours in advance of the appointment. As a courtesy, our office may contact you to remind you of the appointment(s). While certain emergencies and other issues may be taken into consideration, Dental Masters of Lincoln Park reserves the right to apply a fee of $75 to your account for failure to provide adequate notice. Multiple failures to provide adequate notice for canceled appointments could result in dismissal from the practice. Patients arriving more than 15 minutes late to an appointment will be considered a broken appointment and are not guaranteed to be seen that day.

After Hours (Emergency) Appointments: After hours appointments are reserved for true dental emergencies. Unfortunately, many dental emergencies are the result of chronic neglect or non-compliance of previously recommended dental treatment. For this reason, after hours emergency voicemail **(773) 482-3535** will be available only for current patients of record who have had a dental exam within the last 12 months. This is not a guarantee of appointment, but will be triaged by the Doctor or another licensed dentist. If an after hours emergency appointment is indicated, Dental Masters of Lincoln Park reserves the right to charge an after hours appointment fee of $300 (not billable to insurance) in addition to the fees for any services rendered at this appointment.

Guarantee of Payments/Assignment of Insurance Allowances: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service. I authorize payment for services rendered to me to be made directly to this office for allowances otherwise payable to me. These payments shall not exceed the regular charges for this period of treatment. I also understand that I am responsible to pay any charges not covered through my insurance allowances, included but not limited to non-covered services, applicable deductible and/or co-insurances as defined by my policy(ies), or any fees for services in the event that I do not have insurance coverage.

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Dental Masters of Lincoln Park to incur lab, equipment, and labor cost up front. In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of the treatment.

Past Due Balance & Collection Services: Dental Masters of Lincoln Park makes an effort to provide all patients with education and information regarding proposed and completed treatment, as well as the cost associated, in order for each patient to make an informed decision regarding their treatment. I understand that should my past due balance be referred to an attorney or collection agency, I will be financially responsible for any additional cost incurred such as attorney fees, collection agency fees, court cost, ect.

Questions and Complaints for HIPAA

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 if 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.

Designated Privacy Official: Jeffrey Kinka, DMD

2704 N Halsted St.
Chicago, IL 60614
Ph: (773)348-2704
Fx:(773)348-6772
dentalmastersLP@gmail.com

_____ _____
Patient/Responsible Party Name Date

_____
Patient/Responsible Party Signature

Office Policies

I agree to abide by the Office policies listed above. I understand that if I have any questions about these protocols, I may request assistance and further explanation at any time from a Dental Masters of Lincoln Park team member

_____ _____
Patient/Responsible Party Name Date

_____
Patient/Responsible Party Signature

Authorization for Use for Social Media
By Dental Masters of Lincoln Park

Name of Patient:_____

Patient Date of Birth: _____Date:_____

Relationship to Patient:_____

Signature_____

Authorization: By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "Patient"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "Information"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

Purpose: The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability: If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

No Effect on Treatment: This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.