



Referred By: _____

Email: _____

Patient Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Cell Phone:** _____

If under 18 years old, who is the responsible party? _____

Address: _____

City, State, Zip: _____

Emergency contact: _____ **Phone #:** _____

DENTAL INSURANCE INFO:

Dental Insurance Company: _____ **Member ID #:** _____

Are you the Policy Holder? ☐ Yes ☐ NO **If not, who?** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

Do You have secondary dental insurance? ☐ Yes ☐ No **If yes,**

Insurance Company: _____ **Member ID #:** _____

Policy Holder _____ **DOB** _____

Do you take any Blood Thinners? ☐ Yes ☐ No

Do you need to be pre-medicated for any dental procedures? ☐ Yes ☐ No

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

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:

X

Date: _____

NOTICE OF PRIVACY PRACTICES

Well-Articulated Dental Studios

Effective Date: January 1, 2026

THIS NOTICE DESCRIBES HOW MEDICAL 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 MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

605 W Euclid Ave.
Arlington Heights, IL. 60004
PH: (847) 228-6118

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information (“medical information”). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices. We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients’ medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- *healthcare quality assessment and improvement activities;
- *reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;

- *conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- *business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement. We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts. We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please check this box.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- *For public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- *To avert a serious an imminent threat to health or safety;
- *For health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- *For research;
- *In response to court and administrative orders and other lawful process;
- *To law enforcement officials with regard to crime victims and criminal activities;

- *To coroners, medical examiners, funeral directors and organ procurement organizations;
- *To the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- *As authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order. If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- 1) HIV/AIDS;
- 2) Mental Health;
- 3) Genetic Tests (in accordance with GINA 2009)
- 4) Alcohol and drug abuse;
- 5) Sexually transmitted diseases and reproductive health information; and
- 6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

- 1) You have a right to see and get a copy of your health records.
- 2) You have a right to amend your health information.
- 3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
- 4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
- 5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by checking this box.
- 6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
- 7) You have a right to restrict who receives your information.
- 8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
- 9) If you believe your rights are being denied or your health information is not being protected, you can:

a. File a complaint with your provider or health insurer

b. File a complaint with the U.S. Government

10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs you may do so by checking this box.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

PATIENT'S SIGNATURE: _____ Date: _____

Welcome to Well Articulated Dental Studios. The following is an outline of our Office and Payment Policy. Please read it carefully:

❖ Please notify our office when you have a change of address and / or phone number.

APPOINTMENT CANCELLATIONS

❖ When time permits, as a courtesy, we will call to confirm your appointment. However, it is the responsibility of the patient to keep or cancel the appointment whether or not we were able to make contact for information.

❖ We will be unable to reschedule an appointment if you have (3) or more broken appointments.

A 24HR notice is required when cancelling or rescheduling an appointment. Failure to cancel in time will result in a \$50 fee per patient, per appointment.

INSURANCE

❖ We will gladly file your insurance as a courtesy and accept assignment of benefits. However, if the insurance company does not pay after 60 days, it will be your responsibility to pay Well Articulated Dental Studios for the services and resubmit the insurance claim on your own.

❖ You are responsible for payment of any services applied to your deductible.

❖ You are responsible for any payment of any amount over your annual maximum allowance which includes dental services performed in this office, as well as any other offices.

PAYMENT POLICY

❖ Total payment is due for services when treatment is rendered. We accept VISA, MasterCard and Discover.

❖ There will be a 1.5% service charge on any outstanding balances.

❖ Should legal action be instituted to enforce the payment for services rendered, the signer(s) agrees to pay court costs and/or reasonable attorney fees incurred by the holder in such action.

❖ There will be a \$25.00 service charge on all returned checks

Your initial here will certify that you understand and will comply with this policy. _____(Initial)

HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Well-Articulated Dental Studios to use and disclose my protected health information to carry out:

☐ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

☐ Obtaining payment from third party payers (e.g. insurance company)

☐ Day-to-day healthcare operations of the practice (email/text reminders/confirmations of appointments via online services)

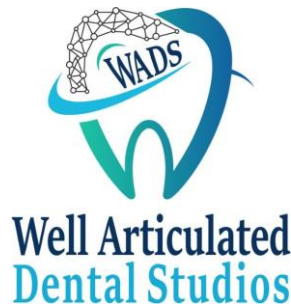
I have also been informed of, and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Well Articulated Dental Studios reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICY & NOTICE

PATIENT'S SIGNATURE: _____

DATE: _____



No-show policy

To ensure the efficient use of medical services and to minimize disruptions in the scheduling process, we have implemented a No-Show Policy. This policy is designed to promote accountability and fairness for all patients seeking medical care.

Definition of a No-Show: A "no-show" is defined as any patient who fails to arrive for a scheduled appointment without providing prior notice of cancellation.

Policy:

1. Appointment Confirmation:

- Patients will receive a reminder call, text message, or email at least 24 hours prior to their scheduled appointment. It is the patient's responsibility to confirm the appointment.

2. Cancellation and Rescheduling:

- Patients are required to provide at least 24 hours' notice if they need to cancel or reschedule an appointment. This allows us to offer the appointment slot to another patient in need of care.
- Cancellations can be made by calling our office at [847-228-6118] or through our online patient portal at [\[wellarticulateddentalstudios.net\]](http://wellarticulateddentalstudios.net).

3. Consequences of No-Show:

- First and second No-Show: Patients will be charged a **no-show fee of [\$50]**. This fee is not covered by insurance and must be paid prior to scheduling any future appointments.
- Third No-Show: may result in the termination of services with our practice.

4. Exceptions:

- We understand that emergencies and unforeseen circumstances can arise. If you are unable to make your appointment due to an emergency, please contact us as soon as possible. We may waive the no-show fee on a case-by-case basis.

5. Reinstatement:

- Patients who have had services terminated due to repeated no-shows may be considered for reinstatement after a review by the practice management. This will typically require a commitment to adhere to the no-show policy in the future.

Patient Acknowledgment:

By scheduling an appointment with our practice, you acknowledge that you have read, understood, and agree to abide by the terms of this No-Show Policy. Thank you for your understanding and cooperation.

Patient Signature: _____ Date: _____