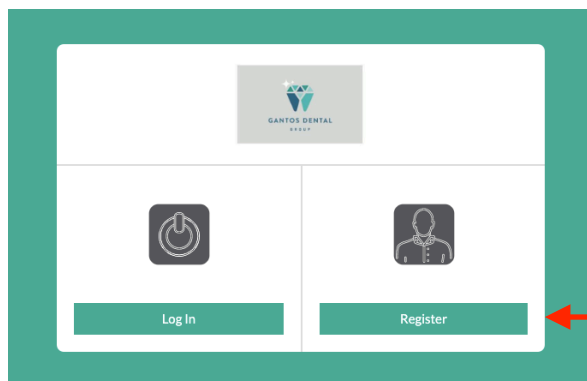


CREATING A MYCHART ACCOUNT

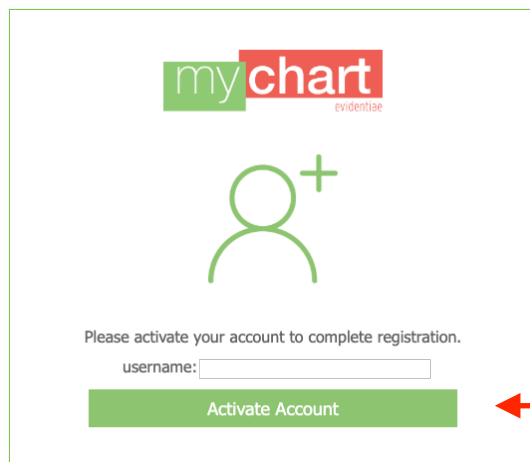
We appreciate the time and attention it takes to fill out new forms. While we know this can feel tedious at times, the quality of our care is greatly impacted by our ability to gather information and understand you as an individual. There is a connection between the oral cavity and the rest of your systemic health. Providing complete and truthful answers assists us in providing comprehensive oral healthcare and keeping you safe. ***Our team is here to make your experience easy and comfortable. Please feel free to contact us with any questions or concerns at anytime: 630-420-9090 or GDG@GantosDentalGroup.com***



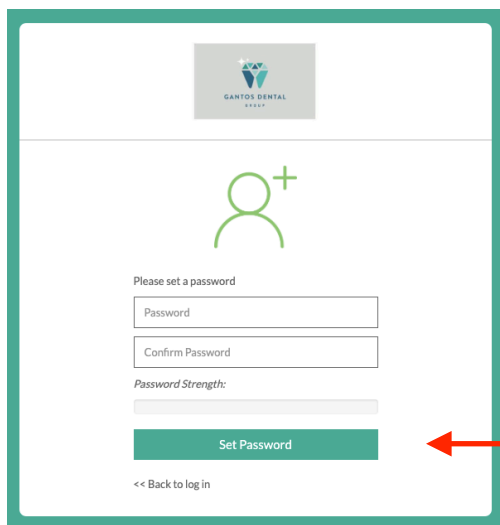
1. After selecting the “MyChart” link, click the “Register” button to make an account. You will be prompted to enter in your email address.



2. A confirmation email will be sent from “Gantos Dental Group.” Be sure to check your spam folder if you do not see this in a few minutes time.



3. Once you open the email, you will be prompted to activate your account by clicking the green “Activate Account” button.



4. Finally you will be prompted to set a password. Click the “Set Password” button when this action is completed.

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

I acknowledge that I received a copy of Gantos Dental Group's Notice of Privacy Practices.

Proceed

Print out Notice of Privacy

5. Review the "Notice of Privacy Practices" and click the acknowledgement at the end. Select "Proceed" to continue.

I. Confidential Information Questionnaire

Patient's Legal Name: Title First Last

Middle Nickname

Date of Birth: Month Day Year

Sex: Male Female

Cell Phone: (201) 555-0123

Email Address

Cell Phone Number (201) 555-0123

Home Phone Number (201) 555-0123

Work Phone Number (201) 555-0123

Home Phone Number (201) 555-0123

Work Phone Number (201) 555-0123

III. Request For Confidential Communication

As my dental care provider, you may do the following with my permission:

- Check all
- Leave message on my voicemail / answering machine
- Contact me via email
- Contact me on the phone numbers provided

I agree that the dental practice may communicate with me electronically at the email address and cell phone number i provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages. I am responsible for providing the dental practice any updates to my email address and cell phone number. I can withdraw my consent to electronic communications by contacting the dental office

Patient's Address United States Address line 1 Address line 2 City

State/Province Zip/Postal Code

Marital Status Single Married / Common-law partner Widowed Divorced / Separated Under 18 Prefer not to answer

Who can we thank for referring you to our office?

- Search Engine Review websites Magazine/Newspaper Friend or family
- Promotional offer Facebook Google Yelp Instagram ADA Website
- Insurance Carrier Dental School Next Door App Family/Friend Dentist
- The Dental School

IV. Confirmation

Do you prefer a reminder before you appointment No, it is unnecessary Yes, it is a helpful reminder

V. Dental Insurance And Financial Information

Dental Insurance Coverage Yes No

II. Emergency Contact Information

Person we may contact in case of an emergency (other than your family home)

Name Relationship

VI. Release Information

You may discuss my healthcare with

- Spouse / Common-law partner
- Children
- Parents

Others: 1.

VII. Assignment & Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I hereby authorize any available insurance benefits to be paid directly to my dentist if he/she accepts such an arrangement.

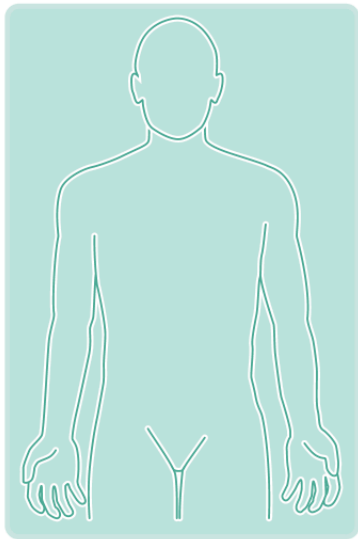
I confirm that I have read and understood the terms & conditions.

I hereby authorize the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me.

I confirm that I have read and understood the terms & conditions.

Finish

6. Complete the "Confidential Information Questionnaire." All responses outlined in red must be filled in before hitting "Finish" to continue.



General Information

Name of Physician:

Their specialty:

When was your most recent physical examination:

the last 2 years

the last 2-5 years

more than 5 years

Purpose:

Your current weight: Unit ↓

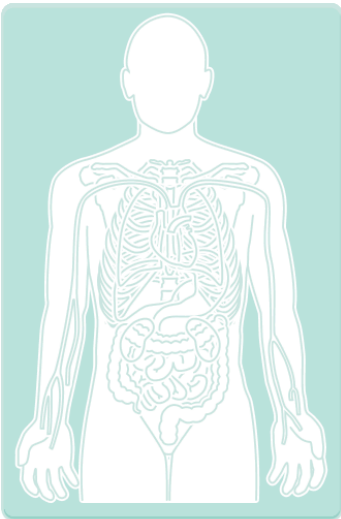
your current height: Unit ↓

What is your estimate of your general health:

Excellent Good Fair Poor

7. Complete the “Health History” section. Use the arrow at the top to toggle back and forth between pages. Click “No” when applicable or click the drop down arrow to expand an answer. Use the blank lines at the bottom to type out more notes if additional details are necessary.

Do you have, or have you ever had any of these diseases/diagnosis/conditions?
Check appropriate box and provide date of onset.



Allergy

No

To medicine ▾

Products or materials used at the dental office ▾

Metals ▾

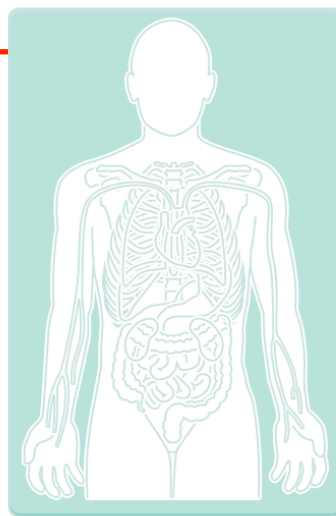
Fruits

Nuts

Other

Allergy Notes:

Do you have, or have you ever had any of these diseases/diagnosis/conditions?
Check appropriate box and provide date of onset.



Allergy

No

To medicine ▾

- aspirin
- ibuprofen
- acetaminophen
- codeine
- penicillin
- erythromycin
- tetracycline
- sulfa

Products or materials used at the dental office ▾

Metals ▾

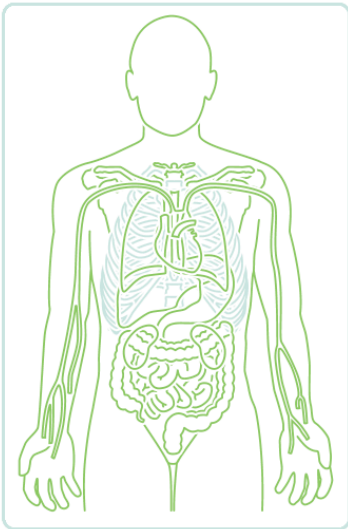
Fruits

Nuts

Other

Allergy Notes:

List all medications supplements, and or vitamins taken within the last two years.



Medications & Supplements

Finish

Medications:

Drug	Dosage	Purpose
drug	dosage	purpose
drug	dosage	purpose

+ add more

Supplements:

Drug	Dosage	Purpose
drug	dosage	purpose
drug	dosage	purpose

+ add more

8. List ALL medications, supplements, and vitamins. Select “+add more” to create additional entries.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

In a moment, you will do a self-examination of your oral health and will receive an assessment regarding your risk. First, please tell us a bit about yourself.



General Dental Information

How would you rate the condition of your mouth?
 Excellent Good Fair Poor

Previous Dentist:

How long had you been a patient?
Months/Years

I see my dentist for routine visits every:
 3 Mo. 4 Mo. 6 Mo. 12 Mo.
 Not routinely

Have you had a non-emergency examination by a dentist within the last...
 2 years 2-5 years 5+ years

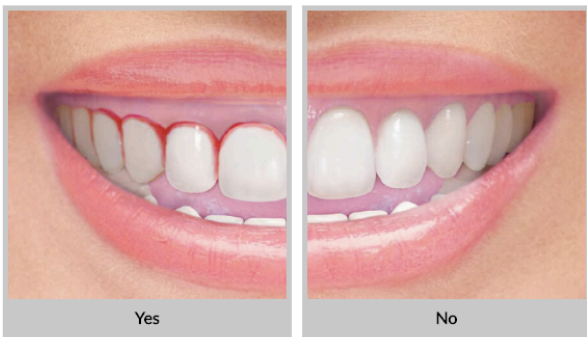
Have you had your Xrays taken within the last...
 1 year 1-3 years 3+ years

Have you had dental treatment (other than cleaning) with in the last...
 3 Mo. 2-5 Mo. 5+ Mo.

9. Complete the "Dental History" section. Use the arrows to toggle between sections.

10. Select "Start" or "Get Started" to begin the visual self-assessment.

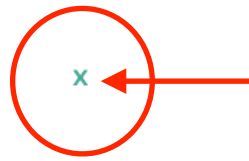
Do you ever spit out blood when you brush or floss your teeth?



11. Select "Yes" or "No" answers. Additional information can be provided in the "Comments" section at the bottom.

Comment

Next

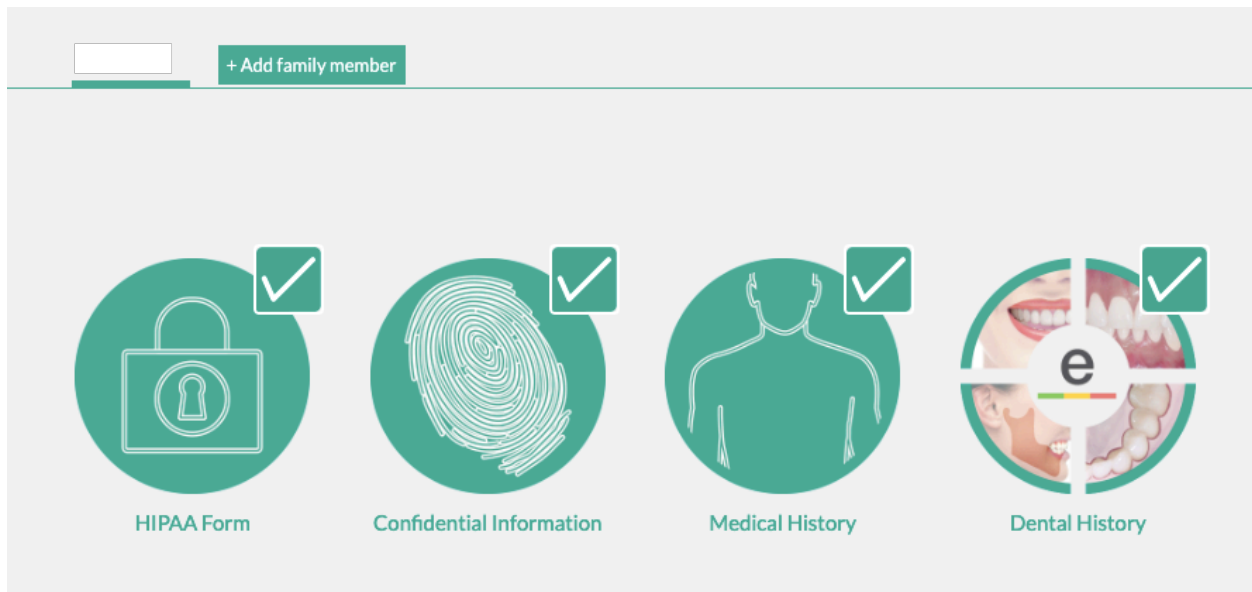


12. When you have finished the visual assessment, a trophy page will appear. Select the “X” in the top right corner to exit the questionnaire and save all of your answers.

Congratulations!! You have finished filling in all the sections!

You can go back and [check your scores.](#)

You can go back and [check your answers](#) or [add a new family member](#)



13. You will automatically be sent back to the homepage where you will see a checkmark next to each completed section. CONGRATULATIONS, you're done!