Patient Registration

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

Patient Name ______________________________ MI _____ Preferred Name _______________ Birth Date _________________

Address ____ City/State ______________________________ Zip ____________

Home Phone ___________________________ Work Phone ___________________________ May we contact you there? Y N

Cell phone ____ Would you like text reminders? Y N

S.S.N. ____________________ __________________ Married _______ Divorced_______ Single_______Child_______

Email ____ Would you like email reminders? Y N

Physician ____________________________ City/State______________________ Phone Number _________________________

Emergency contact ____ Phone Number _______________________________

Whom may we thank for this referral? ____

Person Financially Responsible for the Account

Name ____ Relationship to Patient ________________________________

Home Phone _______________________ Work Phone ________________________ Cell Phone ________________________

Address ____ City/State /Zip____

Employer ____ Occupation ____

If minor, Parent Daytime Phone Number ____

Dental Insurance **YES NO**

Primary Insurance

Employer ______________________________________

Employee ______________________________________

Date of Birth ___________________________________

SS#/Member ID__________________________________

Insurance Company ______________________________

____

Group Number __________________________________

Secondary Insurance

Employer ______________________________________

Employee ______________________________________

Date of Birth ___________________________________

SS#/Member ID__________________________________

Insurance Company ______________________________

____

Group Number __________________________________

Medical History

Last Physical Date ______________________________ Results ____

Are you taking any prescription or over the counter medication now? YES NO

If yes, please list name and dosage ____

Have you been under the care of a physician for any condition or surgery in the past five years? YES NO

If yes, for what? ____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment

YES NO If yes what antibiotic and dose? ____

Are you allergic to any of the following?

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____Metal _____Latex _____Local Anesthetics

Other If yes, please list____

Please circle the following conditions you have or have had:

CARDIOVASCULAR SYSTEM

-Angina (chest pains)
-Arteriosclerosis
-Congenital heart defects
-Coronary artery disease
-Damaged heart valves
-Heart murmur
-Heart attack (Date__________)
-COPD
-Mitral valve prolapse
-Heart valve replacement
-Pacemaker
-High cholesterol
-High/Low blood pressure
-Stroke (Date__________)
-Rheumatic fever
-Tuberculosis
-Emphysema
-Asthma
-Sleep apnea

CIRCULATORY

-Jaundice
-Hepatitis A, B, or C
-Blood transfusion
-Hemophilia
-Sickle cell anemia

IMMUNE SYSTEM

-Immunosuppression
-Diabetes (Type I or II)
-Lupus
-Seasonal allergies
-Chronic sinus congestion
-HIV positive/AIDS
-Sjogren's Syndrome
-Cancer (Date__________)
(Type________________)
(Radiation? Yes / No
Site______________)
(Chemotherapy? Yes / No)

MUSCULOSKELETAL

-Artificial joint(s) Joint________
(Date__________)
-Osteoarthritis
-Rheumatoid arthritis
-Osteoporosis

DIGESTIVE/ENDOCRINE

-Special/restricted diet
-History of anorexia / bulimia
-Ulcers
-Liver disease
-Kidney disease
-GERD/acid reflux
-Gastrointestinal disease
-Gastric bypass
-Hypo/hyperthyroidism

NERVOUS/PSYCHOLOGICAL

-Glaucoma
-Neurological disorders
-Fainting
-Dizziness/vertigo
-Epilepsy or seizures
-Anxiety disorder
-Mental health disorder
(Condition___________)
-Autism
-ADHD

DRUG/MEDICATION USE

-Tobacco use (past/present)
(Type__________________)
(How much____________)
(How long_____________)
-Use of recreational drugs
-Taken bisphosphonates
-Taken Fen-Phen, Redux, or Pondimin

-Sexually transmitted disease
(Specify_________________)

WOMEN

-Currently pregnant
(Due date__________)
-Thinking of becoming pregnant
-Currently nursing
-Currently taking birth control pills

DENTAL HISTORY

Date of last dental visit ________________Last dental cleaning _________________Last Full mouth x-rays _____________

Previous Dentists Name ______________________________Address ____

City/State _________________________________Zip ______________ Telephone ________________________________

How often do you brush your teeth? ________________________________Floss? ________________________

What other dental aids do you use? (Sonicare, Waterpik, Toothpick, etc.) ____________________________________

Do you have any dental problems now? Yes No If yes, please describe: ____________________________________

PAST DENTAL TREATMENT

-Had orthodontic treatment (braces)

-Had oral surgery (Type_________________)

-Been diagnosed with or treated for periodontal (gum) disease

-Diagnosed or treated for oral cancer

-Wear any removable dental appliances (mouthguard, partials, dentures, retainers)

DENTAL CONDITIONS

-Teeth sensitive to hot / cold / biting / sweets

-Jaw clicking or popping (with / without pain)

-Tired jaw

-Chronic head / neck / ear aches

-Muscle pain in face or neck

-Feel you have chronic bad breath

-Gums bleeding or hurting

-Food always catching in teeth

-Mouth breathe while asleep or awake

-Feel like your mouth is always dry

-Have recurrent canker sores (inside mouth)

-Have recurrent cold sores (outside mouth)

Bite/chew your lips or cheeks regularly

CONSENT FOR TREATMENT

I have reviewed this questionnaire and answered its questions accurately and to the best of my knowledge. I understand that the answers I have provided will be used by Dr. Buchholtz to determine appropriate dental treatment. I agree to notify Dr. Buchholtz if any health changes occur. I authorize Dr. Buchholtz and the dental staff to perform the necessary dental services. I authorize the dental staff to release all information necessary to secure payment of benefits. I authorize my insurance company to pay Dr. Buchholtz directly. I authorize the use of this signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand that I am financially responsible for any charges not covered by my dental insurance.

Patient ____ Date____________________

Parent or responsible party ________________________________

Relationship to patient ____________________________________

FAMILY DENTAL PRACTICE

NOTICE OF PRIVACY PRACTICES

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 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 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 the Notice while it is in effect. This Notice takes effect April 1, 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, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We may 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 must have your written permission before 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 must have your written permission before 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.

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 health. 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 you 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, radiographs, 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: Under Wisconsin law, we must have you written permission before we may disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence or other crimes. We may report child abuse and the abuse or neglect of a vulnerable adult as allowed by Wisconsin layw.

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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose you health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS.

Access: You have the right to look at or get copies of you 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 the 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.)

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: While we are allowed to determine whether we agree to your request to restrict our use and disclosure of your protected health information, Wisconsin law requires that we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.

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 of 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, you are entitled to receive this Notice in written form.

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 may also 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 of with the U.S. Department of Health and Human Services.

Contact Officer: Sue Buchholtz
Phone: (920) 261-8228 Fax: (920) 261-8219
1518 Doctors Court
Watertown, WI 53094

FAMILY DENTAL PRACTICE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: INDIVIDUAL GIVING CONSENT

(LABEL INSERTED HERE)

SECTION B: TO THE INDIVIDUAL—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as set forth in our Privacy Practices Notice. Your HIV test results, if any, may be disclosed to persons and /or circumstances specified in Wisconsin Statutes 252.15(5)(a). A listing of those persons and /or circumstances is available upon request. Under Wisconsin law, this form is to obtain an individual's written permission for (a) our use of the individual's patient health care records, HIV test results and mental health treatment records to carry out treatment, payment activities and health care operations and (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations and (c) the listing of an individual's general condition in our facility directories and (d) our disclosure of you patient health care records, mental health treatment records and HIV test results for disaster relief purposes as permitted by law and to people involved in your care of payment for that care. This form should not be used to obtain written permission for the disclosure of mental health treatment records or HIV test results unless the name of the recipient is listed on this form.

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best intereset in allowing a person acting on you behalf to pick up filled prescriptions, medical supplies, radiographs or other similar forms of protected health information.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Will Buchholtz
Phone: (920) 261-8228 Fax: (920) 261-8219
1518 Doctors Court
Watertown, WI 53094

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 Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of 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.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ________________________________ Date: ______________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____ Relationship to Patient: ________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ________________________________ Date: ______________________________

Turn to Back Side

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

Please Print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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