SHEBOYGAN DENTAL REGISTRATION FORM

Patient's Name:______________________________ **Date of Birth:**__________ ☐ **Male** ☐ **Female**
LAST First Initial

If Child: Parent's Name:______________________
How do you want to be addressed ______________________

☐Single ☐ Married ☐Separated ☐Divorced ☐ Widowed ☐ Minor

Residence – Street ______________________

City ______________ State _____ Zip________

Main Phone:______________ ☐Cell ☐Landline

Other Phone: ______________ ☐Cell ☐Landline

Work Phone:______________x ________

eMail ______________________

BEST WAYS TO CONTACT YOU - CONFIRM YOUR APPOINTMENTS
☐**Landline** ☐ **Cell Phone** ☐ **Text Message** ☐ **Email** ☐ **Work**

Patient/Parent Employed by______________________

Present Positiion ______________________

How Long Held ______________________

Spouse/Parent Name ______________________

Spouse/Parent Employed by ______________________

Present Position ______________________

How Long Held ______________________

Who is Responsible for this account ______________________

Drivers License No ______________________

Method of Payment ☐ **Insurance** ☐ **Cash** ☐ **Credit Card** ☐**Payment Plan**

Purpose of Appointment Today:______________________

Other Family Members in this Practice ______________________

____

Whom may we THANK for this referral ______________________

Patient/Parent Social Security No ______________________

Spouse/Parent Social Security No ______________________

Someone to notify in case of emergency – NOT living with you

____
Name Phone

PRIMARY DENTAL INSURANCE

☐ Card Copied

Subscribers Name ______________Date of Birth________

Business Name ______________________

Insurance Company ______________________

Claim Address ______________________

____

Telephone ______________________

Policy/Group Number ______________________

Subscribers ID ______________________

SECONDARY DENTAL INSURANCE

☐ Card Copied

Subscribers Name ______________Date of Birth________

Business Name ______________________

Insurance Company ______________________

Claim Address ______________________

____

Telephone ______________________

Policy/Group Number ______________________

Subscribers ID ______________________

CONSENT:
I consent to the diagnostic procedures and treatment by the dentist for proper dental care.
I consent to the dentist's use and disclosure of my records (or my chil's records) to carry out treatment , to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

____

____

My consent to disclosure of records shall be effective until I revoke it in writing.
I authorize payment directly to my dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance or payor f my dnetal benefits may pay less than the actual bll for setrvices, and that I an financially responsible for payments in full of al the accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, by my dental care payor.
I attest to the accuracy f the informaion on this page

Patient/Guardian Signature:______________________
Date Signed ______________________

REGISTRATION

Sheboygan Dental Care
Medical History Form

Patient's Name ____ **Date of Birth** ____________
Last First Initial

CHOOSE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER CHOOSE "?"

COMMENTS

1. Physician's Name________________________Tel: (____)__________
2. Are you treating with a physician currently ☐**Yes** ☐**No**
3. When was your last complete physical examination?__________________
4. Are you taking any medications or substances? ☐**Yes** ☐**No**
5. Do you routinely take health related substances? ☐**Yes** ☐**No**
6. **Are you allergic to any medications or substances? (please list)** ☐**Yes** ☐**No** ☐**?**
7. Do you have any other allergies or hives? ☐**Yes** ☐**No** ☐**?**
8. Do you have any problems with penicillin, antibiotics, and anesthetics? ☐**Yes** ☐**No** ☐**?**
9. Are you sensitive to any metals or latex? ☐**Yes** ☐**No** ☐**?**
10. Have you ever been told you might have heart disease? ☐**Yes** ☐**No** ☐**?**
11. Do you have a pacemaker, an artificial heart value implant, or been diagnosed with mitral valve prolapse? ☐**Yes** ☐**No** ☐**?**
12. Have you ever had rheumatic fever? ☐**Yes** ☐**No** ☐**?**
13. Are you aware of having any heart murmurs? ☐**Yes** ☐**No** ☐**?**
14. Do you have HIGH or LOW blood pressure? ☐**Yes** ☐**No** ☐**?**
15. Have you ever had a serious illness or major surgery? ☐**Yes** ☐**No** ☐**?**
16. Have you ever had radiation treatment or chemo treatment? ☐**Yes** ☐**No** ☐**?**
17. Have you ever taken Fosamax, Zometa, or any bisphosphonates for bone tumor, excessive calcium in your blood or osteoporosis? ☐**Yes** ☐**No** ☐**?**
18. Do you have inflammatory disease such as arthritis or rheumatism? ☐**Yes** ☐**No** ☐**?**
19. **DO YOU HAVE ARTIFICAL JOINTS OR PROSTHESIS?** ☐**Yes** ☐**No** ☐**?**
20. Do you have any Blood Disorders, such as anemia, leukemia, etc? ☐**Yes** ☐**No** ☐**?**
21. Have you ever bled excessively after being cut or injured? ☐**Yes** ☐**No** ☐**?**
22. Do you have any stomach problems? ☐**Yes** ☐**No** ☐**?**
23. Do you have any kidney problems? ☐**Yes** ☐**No** ☐**?**
24. Do you have any liver problems? ☐**Yes** ☐**No** ☐**?**
25. Are you diabetic? ☐**Yes** ☐**No** ☐**?**
26. Do you have fainting or dizzy spells ☐**Yes** ☐**No** ☐**?**
27. Do you have asthma? ☐**Yes** ☐**No** ☐**?**
28. Do you have epilepsy or seizure disorders? ☐**Yes** ☐**No** ☐**?**
29. Do you or have you had venereal or sexual transmitted disease? ☐**Yes** ☐**No** ☐**?**
30. Have you tested HIV – POSITIVE? ☐**Yes** ☐**No** ☐**?**
31. Do you have AIDS? ☐**Yes** ☐**No** ☐**?**
32. Have you had or do you test positive for hepatitis? ☐**Yes** ☐**No** ☐**?**
33. Do you or have you had T.B.? ☐**Yes** ☐**No** ☐**?**
34. Do you smoke, chew, or use snuff or any other forms of tobacco? ☐**Yes** ☐**No** ☐**?**
35. Do you regularly consume more two alcoholic beverages a day? ☐**Yes** ☐**No** ☐**?**
36. Do you habitually use controlled substances? ☐**Yes** ☐**No** ☐**?**
37. Have you had psychiatric treatment? ☐**Yes** ☐**No** ☐**?**
38. **FEMALES** -Are you pregnant or do you suspect you may be? ☐**Yes** ☐**No** ☐**?**
39. **FEMALES** -Do you use any birth control medications? ☐**Yes** ☐**No**
40. Have you taken any fen-phen, redux or any weight loss products? ☐**Yes** ☐**No**
41. Do you have any disease condition, or problem not listed? If so, Explain__________________
42. Is there anything else we should know about your health that we have not covered in this form? __________
43. Would you like to speak to Dr. Schoenenberger privately about any problem? ☐**Yes** ☐**No**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN SIGNATURE ______________________ **DATE** __________

DENTIST's SIGNATURE ______________________ **DATE** __________

Sheboygan Dental Care
Dental History Form

Patient's Name ________________ (Last) ________________ (First) ________ (Initial) **Date of Birth** ____________

CHOOSE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Purpose of initial visit ________________
2. Are you aware of a problem? ________________
3. How long since your last dental visit? ________________
4. What was done at that time? ________________
5. Previous dentist's name? ________________
   Phone Number ________________
6. When was the last time your teeth were cleaned? ________________
7. Have you made regular visits? ☐**Yes** ☐**No**
   How often: ________________
8. Were dental x-rays taken? ☐**Yes** ☐**No**
9. Have you lost any teeth or have any teeth been removed? ☐**Yes** ☐**No**
   Why? ________________
10. Have they been replaced? ☐**Yes** ☐**No**
11. **How have they been replaced?**
    a. Fixed Bridge ________________ Age ________
    b. Removable Bridge ________________ Age ________
    c. Denture ________________ Age ________
    d. Implant ________________ Age ________
12. Are you unhappy with the replacement? ☐**Yes** ☐**No**
    If yes, explain ________________
13. Would you like to know about permanent replacements? ☐**Yes** ☐**No**
14. Have you ever had any problems/complications with previous dental treatment? ☐**Yes** ☐**No**
    If yes, explain: ________________
15. Do you clench or grind your teeth? ☐**Yes** ☐**No**
16. Does your jaw click or pop? ☐**Yes** ☐**No**
17. Have you experienced any pain or soreness in the muscles or your Face or around your ear? ☐**Yes** ☐**No**
18. Do you have frequent headaches, neck aches or shoulder aches? ☐**Yes** ☐**No**
19. Does food get caught in your teeth? ☐**Yes** ☐**No**
20. Are your teeth sensitive to: ☐**HOT?** ☐**COLD?** ☐**SWEETS?** ☐**PRESSURE?**
21. Do your gums bleed or hurt? ☐**Yes** ☐**No**
    When? ________________
22. Do you experience dry mouth? ☐**Yes** ☐**No**
23. How often do you brush your teeth? ________ When? ________
24. Do you use dental floss? ☐**Yes** ☐**No**
    How often? ________________
25. Are any of your teeth loose, tipped, shifted or chipped? ☐**Yes** ☐**No**
26. Are you unhappy with the appearance of your teeth? ☐**Yes** ☐**No**
27. How do you feel about your teeth in general?
28. Do you feel your breath is offensive at times? ☐**Yes** ☐**No**
29. Have you ever had gum surgery? ☐**Yes** ☐**No**
    What? ________________
    Where? ________________
    When? ________________
30. Have you had orthodontic work? ☐**Yes** ☐**No**
31. Have you had any unpleasant dental experience or is there anything about dentistry that you strongly dislike? ________________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN SIGNATURE ________________ **DATE** ________

DENTIST's SIGNATURE ________________ **DATE** ________

DENTAL HISTORY

©2013 Wisconsin Dental Association
(800) 243-4675

NOTICE OF PRIVACY PRACTICES

Effective Date: ______________________________

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.

Title: Privacy Officer

Telephone: (______) ______–____________

Fax: (______) ______–____________

Email:

Address:

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 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.

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 that 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 if applicable. 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 security 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 or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care 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. 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 or had a relationship with you and the medical information is for that provider’s or plan’s health 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 the information. You may take back or “revoke” your written authorization at any time in writing, 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 a 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 authorized, you may opt out of any of these communications.

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 only 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.

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.

© Michael Best & Friedrich, LLP

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, and adult abuse, neglect or domestic violence;
- to avert a serious and 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.

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 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;
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

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

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 to our Privacy Officer.

You also may 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, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

© Michael Best & Friedrich, LLP

SHEBOYGAN DENTAL, SC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________ Date of Birth:______________

Address:______________________________ Zip Code:______________

Telephone:______________ **Cell Phone**:______________ Work Phone:______________

Email:______________________________ Social Security #:______________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING 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.

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.

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

Contact Person: **Jerilynn Schroeder** Telephone: **920-452-8042** Fax: **920-452-0142**

Address: **2202 Indiana Avenue - Sheboygan, WI 53081**

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 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.

PRINT NAME

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 heath care operations.

SECTION C: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

Initial that you are acknowledging the receipt of the Privacy Practice Notice for Sheboygan Dental. ______________

SECTION D: CONSENT GIVEN TO COMMUNICATE WITH OTHER PERSONS:

Please list any person with whom you may want to give access to your Personal Health Information at Sheboygan Dental.

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION