WELCOME

Patient's Name____
First Initial Last

Date________________ Date of birth_____________________

Male Female

If child: Parent's Name__________________________________

Single Married Separated Divorced Widowed Minor

Home-Street____

City______________________ State_______ Zip__________

Telephone: Home__________________ Cell ________________

Email ____

Patient/Parent employed by:______________________________

Work phone:__________________ SS#____________________

Spouse/Parent Name ___________________________________

Spouse employed by:___________________________________

Work phone:__________________ SS#____________________

Who is responsible for this account:_______________________

Method of payment: Insurance Cash Credit Card

Purpose of Visit _______________________________________

Other Family Members in this Practice_____________________

Whom may we thank for this referral?______________________

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsiible for payment of services not paid, in whole or in part by my dental care payor.

Dental Insurance 1st Coverage

Employee Name___________________ Date of birth_________

Employer Name_________________________ Years_________

Name of Insurance Co.__________________________________

<GIVE CARD TO RECEPTIONIST TO SCAN PLEASE>

Dental Insurance 2nd Coverage

Employee Name____________________ Date of birth________

Employer Name___________________________ Years_______

Name of Insurance Co.__________________________________

<GIVE CARD TO RECEPTIONIST TO SCAN PLEASE>

Dental History

Date of last dental visit____________________________________

Date of last cleaning_____________________________________

Please circle appropriate answer

Teeth Sensitive to Hot or Cold Yes or No Bleeding gums Yes or No

Pain or Swelling of gums Yes or No Sensitive to Sweets Yes or No

Jaw, joint pain, [popping or clicking Yes or No

Do you have a denture/partial? Yes or No If so, how old is it?________

Are you satisfied with the appearance of your teeth? Yes or No

Why did you change dentists?___________________________________

Someone to notify in case of emergency not living with you:

____
Name Relationship Phone

I attest to the accuracy of the information on this page.

____
PATIENT'S OR GUARDIAN'S SIGNATURE

____
DATE

Patient's Name____ Date of birth____________________
First Mi Last

Medical Doctor ______________________Address ______________________________Last physical exam_________

Are you under a physician's care now? YES NO If so, for what? ____

What surgeries have you had?
____
____

What drugs or medicines are you taking now? ____

Are you taking any blood thinners? ____

Do you have artificial joints or implants? YES NO Are you pregnant? YES NO If so, what tri-mester? ____________

IS THERE A PERSONAL HISTORY OF OR PROBLEM WITH: **Please circle the appropriate answer**.

Mitral valve prolapse	Yes No	Lyme's disease	Yes No	Diabetes	Yes No
Valve replacement	Yes No	Abnormal blood pressure	Yes No	Hepatitis, type__________	Yes No
Rheumatic fever	Yes No	Slow wound healing	Yes No	Chronic sinus problems	Yes No
Heart murmur	Yes No	Oral soft tissue lesions	Yes No	Fainting spell or seizure	Yes No
Heart trouble	Yes No	Periodontal disease	Yes No	Epilepsy	Yes No
Pacemaker	Yes No	Frequent cold sores	Yes No	Stomach ulcers	Yes No
Bleeding problems	Yes No	Orthodontics	Yes No	Jaundice or liver disease	Yes No
Blood transfusion	Yes No	Asthma	Yes No	Unintentional weight loss	Yes No
Blood disease	Yes No	Inflammatory rheumatism	Yes No	Drug or alcohol abuse	Yes No
HIV positive	Yes No	Kidney trouble	Yes No	Visual/hearing impairments	Yes No
Anemia	Yes No	Arthritis	Yes No	Radiation/Chemotherapy	Yes No
Tuberculosis	Yes No	Special needs - Mentally/Physically handicapped	Yes No	Birth Control Medications	Yes No
Osteoporosis	Yes No	Depression	Yes No	Alcohol Sensitivity	Yes No
Acid Reflex	Yes No	Fibromyalgia	Yes No	Chronic Fatigue Syndrome	Yes No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? **Please circle all that apply.**

Penicillin Other medications Local anesthetic Codeine Aspirin Sulfa drugs Sulfite Other antibiotics Rubber, latex
Metals- gold, silver, nickel, etc. Chlorhexidine Other:__________ **TOBACCO USE?** Cigarettes Pipe Smokeless tobacco

Do you have any disease condition, or problem not listed? If so, explain ____________________________________

Would you like to speak privately with the Doctor about any problem? Yes No ______________________________

Signature: ____ Date ____________________

Updates:

MEDICAL HISTORY

Village Family Dental Associates

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this Notice while it is in effect. This Notice takes effect April 14,2003, 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 applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change 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 use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Healthcare Operations: We may use and disclose your health information for 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. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

Your Authorization: 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 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or location a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your 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 request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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 must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:

- we may have violated your privacy rights;
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

Village Family Dental Associates P.O. Box 39 Prairie du Sac, Wi. 53578 608-643-8505 FAX: 608-643-809

Village Family Dental
WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's patient health care 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.

SECTION A: Individual giving consent.

Name: ____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care 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.

SECTION B: The uses and disclosures being authorized.

Our Use of Medical Information: By signing this form, you will consent to our use of your patient dental/ health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.
By checking the box below, you indicate your consent to:

☐ Our disclosure of your patient dental/ health care records to the following persons, including those involved in your care or payment for that care. [Example: Spouse, children, guardian,etc.]

_______________________________________ ____

_______________________________________ ____

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

Our Disclosure of Medical Information. By signing this form, you will consent to our disclosure of your patient dental/ health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: Village Family Dental Associates Phone: 608-643-8505
FAX: 608-643-8097 Address: P.O. Box 39 Prairie du Sac, Wi. 53578

INDIVIDUAL'S SIGNATURE

I,____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected dental/ health information, as described in this form.

Signature: ____ Date:______________________________________

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

Personal Representative's Name:____

Relationship to Individual: ____