Today's Date_____

DeForest DENTAL SERVICES

Patient Information

Patient Name _____
Last First Middle

I Prefer to Be Addressed as _____

Date of Birth_____ Age_____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient Address _____

City_____ State_____ Zip Code _____

Social Security #_____ Sex ❑ M ❑ F

Driver's Lic. #_____ Cell Phone _____

Home Phone _____ Work Phone _____

Can we reach you at your work number? ❑ Yes ❑ No

Employer _____

Occupation _____

E-mail Address* _____

For confirmation of appointments and company information only.
We take your privacy very seriously.

Emergency Contact Person _____

Relationship_____

Home Phone _____ Work Phone _____

Account Information

Person Responsible for the Account

Name _____

Relation to Patient _____

Billing Address _____

City_____ State_____ Zip Code _____

Social Security #_____ D.O.B. _____

Home Phone _____ Work Phone _____

Medical Insurance Information

Medical Insurance

Insurance Company _____

Subscriber Name _____

Subscriber D.O.B. _____

Insurance Co. Phone # _____

Dental Insurance Information

Primary Insurance

Insurance Company _____

Subscriber Name _____

Subscriber D.O.B. _____

Insurance Co. Phone # _____

Subscriber's Employer_____

Group #_____ Subscriber ID # _____

Patient's Relationship to Subscriber

❑ Self ❑ Spouse ❑ Child ❑ Student Dependent

Secondary Insurance (if applicable)

Insurance Company _____

Secondary Insurance Subscriber Name_____

Secondary Subscriber D.O.B. _____

Secondary Subscriber SS # _____

Insurance Co. Phone # _____

Secondary Subscriber's Employer_____

Group #_____ Subscriber ID # _____

Patient's Relationship to Subscriber:

❑ Self ❑ Spouse ❑ Child ❑ Student Dependent

Authorization

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment, unless prior arrangements have been approved. I authorize release of any information relating to claims filed by DeForest Dental Services. I wish to assign benefits to DeForest Dental Services, and understand that I am responsible for any amount not covered by my insurance. Furthermore, I understand that a 24-hour notice is required to change appointments.

Patient/Guardian Signature **Date**

X_____ _____

(please turn over and complete other side)

HEALTH INFORMATION

Health History

Patient Name _____

Patient Date of Birth _____

Former Dentist _____

Location _____

Phone Number _____

Last Visit _____

Personal Physician _____

Clinic Location _____

Phone Number _____

Medications

Please list any medication you are currently taking
(including over-the counter medicines)

Medication	Reason

Are you currently taking any blood thinners? ❑ Yes ❑ No

Are you currently taking birth control pills? ❑ Yes ❑ No

Have you ever taken Phen-fen? ❑ Yes ❑ No

Allergies

Check all that apply:

❑ Amoxicillin ❑ Erythromycin ❑ Penicillin

❑ Anesthetics ❑ Latex ❑ Aspirin

❑ Metals/Jewelry ❑ Tetracycline ❑ Codeine

❑ Sulfa ❑ Other _____

If yes to any, please describe symptoms _____

_____

_____

Conditions

Check all that apply (past or present)

❑ Alzheimer's/Memory Loss ❑ Heart Murmur

❑ Anemia ❑ Heart Surgery

❑ Anorexia/Bulimia ❑ Hemophilia/Abnormal Bleeding

❑ Arthritis ❑ Hepatitis A B C D

❑ Artificial Joints (date_____) ❑ High/Low Blood Pressure

❑ Artificial Heart Valves ❑ HIV/AIDS

❑ Asthma/Hay Fever ❑ Kidney Problems

❑ Blood Transfusions ❑ Liver Disease

❑ Cancer/Chemotherapy ❑ Migraines

❑ Cold Sores/Herpes ❑ Mitral Valve Prolapse

❑ Congenital Heart Defect ❑ Pacemaker

❑ Diabetes ❑ Radiation Treatments

❑ Difficulty Breathing ❑ Rheumatic/Scarlet Fever

❑ Drug/Alcohol Abuse ❑ Shingles

❑ Emphysema ❑ Sinus Problems

❑ Epilepsy/Seizures/Fainting ❑ Smoking/Tobacco

❑ Gastrointestinal Disorder ❑ Snoring/Sleep Apnea

❑ Glaucoma (Narrow Angle) ❑ Stroke

❑ Headaches (Severe, Frequent) ❑ Tuberculosis

❑ Hearing impaired ❑ Tumor Growth

❑ Heart Attack ❑ Venereal Disease

❑ Other Surgeries _____

Have you been told that you need antibiotics before a dentist appointment? ❑ Yes ❑ No

Please explain _____

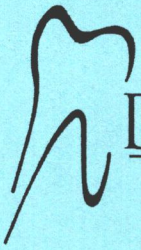
Are you pregnant? ❑ Yes ❑ No Due Date _____

Are you currently nursing? ❑ Yes ❑ No

Would you like to speak to the doctor privately about any health concerns? ❑ Yes ❑ No

Health Information Update

Date	Changes	No Change	Patient Initials	Date	Changes	No Change	Patient Initials



DEFOREST
DENTAL

Dr. Courtney Mann
210 N. Main St., Suite 103
DeForest, WI 53532
(608) 846-3948

Consent for Treatment

- I hereby authorize Dr. Mann and her staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.

- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as requited to provide proper care.

- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

- I give consent to the doctor's, or designated staff's, use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service.

_____ ____/____/____
Patient's Signature Date

_____
Witness

_____ _____
Parent/Responsible Party Signature Relationship to Patient

DEFOREST DENTAL

Dr. Courtney Mann
210 N. Main St., Suite 103
DeForest, WI 53532
(608) 846-3948

Truth-in-Lending Statement

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements, in writing, must be paid for in cash at the time of service.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making insurance collections, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon. The patient will be responsible for all costs of collecting any past-due accounts, including reasonable attorney's fees.

I understand that fee estimates for dental care are valid only for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless I object, in writing, within the time payment is due. I further agree that if this office waives any breach of any condition hereunder, this shall not institute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I hereby consent to such procedures that may be prescribed. I grant my permission to you, or your assignee, to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party: _____

Relationship to patient: _____ Date: _____

DeForest Dental
HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient | Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses, step-parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

Privacy Officer Name and Contact Number: Kristy Denk - 608-846-3948 Email: kdenk@deforestsmiles.com

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____

Other (please describe) _____

Signature of Privacy Officer_____