Szmanda
Dental Center

PATIENT INFORMATION AND HEALTH HISTORY

Today's Date: _____

Patient Name: _____ ☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed

Date of Birth: _____ E-mail: _____

Patient Address: _____
Street *City/State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Social Security No.: _____

Dental Insurance Carrier: _____ Insurance No.: _____

Hobbies (Interests): _____

Spouse Name (If married, otherwise responsible party): _____ Spouse Date of Birth: _____

Spouse Employer: _____ Spouse Work Phone: _____

Spouse Dental Insurance Carrier: _____ Insurance No.: _____

Spouse Social Security No.: _____

DENTAL HISTORY

Date of last dental exam (approximate): _____

Previous dentist's name: _____ City: _____

Do you have any problems in your mouth now? ☐ Yes ☐ No

Do you feel nervous about having dental treatment ☐ Yes ☐ No Explain _____

Have you ever had a bad experience in the dental office? ☐ Yes ☐ No Explain _____

Check any of the following which you experience:

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums How long: _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, *i.e., fingernail biting, cheek biting, etc.*

Check any of the following that you use:

- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush: ☐ Hard ☐ Soft
- ☐ Brushing: _____/day
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements

CONTINUED ON REVERSE

RIB MOUNTAIN
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WITTENBERG
202 E. Grand Ave.
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PATIENT INFORMATION AND HEALTH HISTORY

Present Physician: _____ Phone Number: _____

Are you having any health concerns at this time? ☐ Yes ☐ No

Explain:_____

Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No

Explain:_____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Explain:_____

Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No

Explain:_____

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex, or any drugs or medications? ☐ Yes ☐ No

Explain:_____

Have you taken any medicines or drugs during the past two years? ☐ Yes ☐ No

Explain:_____

Check any of the following which you have had or have at present:

- ☐ Heart Failure
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Scarlet Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Parkinson's Disease
- ☐ Bruise Easy
- ☐ Emphysema
- ☐ Cough
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ X-ray or Cobalt Treatment
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Cold Sores
- ☐ Rheumatism
- ☐ Cortisone Medicine
- ☐ Glaucoma
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Treatment
- ☐ Alcohol Addiction
- ☐ AIDS
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Blood Transfusion
- ☐ Drug Addiction
- ☐ Hemophilia
- ☐ Venereal Disease (Syphilis, Gonorrhea)
- ☐ Genital Herpes
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Sickle Cell Disease
- ☐ Other *please list:*

_____

Do you need to take pre-medication for dental work due to having artificial joint or heart valve?
☐ Yes ☐ No If Yes, please state reasoning for pre-med: _____

WOMEN: Are you pregnant now? Ye☐ N☐ If yes, how far along? _____

Are you presently taking oral contraceptives? ☐ Yes ☐ No Do you anticipate becoming pregnant? ☐ Yes ☐ No

The information on this page is correct to the best of my knowledge. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I also understand the use of anesthetic agents embodies a certain risk. The risks include, but are not limited to pain, swelling, bruising and permanent anesthesia. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Date: _____ Signature: _____
Patient or Responsible Party

IN-OFFICE USE ONLY

____/____	_____	_____	_____
BP	P	Reviewed by	Date

MEDICAL UPDATES I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	NONE ☐	_____	____/____	_____
_____	_____	NONE ☐	_____	____/____	_____
_____	_____	NONE ☐	_____	____/____	_____
_____	_____	NONE ☐	_____	____/____	_____

Szmanda Dental Center

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin Law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: Individual giving consent

Name: _____

Patient Name: (If different than above) _____

Address: _____

Telephone: _____

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 dental office's Notice of Privacy Practices 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 Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following person, including those involved in your care or payment for that care.
Please list the person(s) you would like involved in your care or payment for that care:

_____ _____

_____ _____

_____ _____

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 health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

CONTINUED ON REVERSE

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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 of revocation to the Contact Office checked 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.

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INDIVIDUAL'S SIGNATURE

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

Signature: _____ Date: _____

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

Personal Representative's/Parent Name: _____

Relationship to Individual: _____

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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 acknowledgment 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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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to maintaining high standards of comprehensive dental care. Financial considerations should not be an obstacle to obtaining care. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we provide the following payment options.

FOR PATIENTS WITHOUT INSURANCE

We ask that you PAY IN FULL the day of service. We accept CASH, CHECK, or CREDIT CARD — MasterCard, Visa, Discover, American Express, and Care Credit. To demonstrate our appreciation we will extend a five percent (5%) reduction of your total fee.

FOR PATIENTS WITH INSURANCE

We are happy to assist you in filing the necessary forms. The insurance relationship constitutes an agreement between the carrier and the patient. We can make no guarantee of estimated coverage for payment. However, be assured we will do everything possible to help you receive the full benefits of your policy. **We ask that YOUR CO-PAY BE PAID AT THE TIME OF SERVICE.**

MONTHLY PAYMENT PLAN

For balances OVER $300.00

1. Pay one half on the day procedure is started and the balance upon completion.
2. To qualified applicants, an Interest Free Plan may be offered by CareCredit. No interest charges are assessed if paid within the specified interest free periods of six(6) or twelve(12) months with no prepayment penalties. Get pre approved at CareCredit.com

I understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependants in this dental office. Any Insurance Claim not paid in full after 60 days will become my responsibility to pay at that time.

Thank you for trusting us with your dental care and for understanding our Financial Policy. Please feel free to contact our staff if you have any questions regarding the payment options described above. I have read and agree to this financial policy.

DATE: _____

SIGNED: _____

PATIENT OR RESPONSIBLE PARTY

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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

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 you rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (03/05/15), 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 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.

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 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 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 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, but only if you agree that we may do so.

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 death. 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 judgement disclosing only health information that is directly relevant to the person's involvement in your 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, x-rays, 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: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

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

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 obtain a form to request access by using the contact information listed at the time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.)

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: 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).

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 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 Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

Failed Appointment: If you repeatedly miss your scheduled appointment(s), we reserve the right to charge you a cancellation fee as it is at the expense of our staff's time and wages, and an inconvenience to our other potential patients.

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 contact us at one of the locations 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 complain 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.