PATIENT REGISTRATION

Patient's Last Name _____ First Name _____ M.I. _____ Date of Birth _____

Preferred name, how do you wish to be addressed? _____

If minor, what is Parent's name? _____

Are you? ○ Single ○ Widowed ○ Married ○ Divorced

Address _____

City _____ State _____ Zip _____

Patient/Parent Employer _____

Present position _____ How long held? _____

Telephone# Home _____ Business _____ Cell _____

Email address _____

Spouse/Parent Name _____

Spouse/Parent Employer _____

Present position _____ How long held? _____

Who is responsible for this account? _____

Driver's license number _____

Patient/Parent Social Security Number _____

Spouse/Parent Social Security Number _____

Other family members in this practice _____

Who may we thank for this referral? _____

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

DENTAL INSURANCE FIRST COVERAGE

Employee Name _____ Employee Date of Birth _____

Employer Name _____

Name of Insurance Company _____

Address _____

Telephone # _____

Social Security or Subscriber Number _____ Union Local or Group Number _____

Relationship to patient _____

DENTAL INSURANCE SECOND COVERAGE

Employee Name _____ Employee Date of Birth _____

Employer Name _____

Name of Insurance Company _____

Address _____

Telephone # _____

Social Security or Subscriber Number _____ Union Local or Group Number _____

Relationship to patient _____

CONSENT:

I understand this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical or insurance status. Should further information be needed, Maple Grove Dental, SC has my permission to ask the respective health or dental care provider or other agency for information required and each may release necessary information required to carry out treatment, obtain payment, and/or health care operations that are related to treatment or payment.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with this informed consent.

I also give permission for the doctor or his staff to use any photos taken for consulting, lecturing, and publishing or education purposes.

I understand that my patient portion is due in full at time of treatment.

The above information is accurate to the best of my knowledge.

Patient's/Guardian's Signature _____ Date _____

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICE

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

I request in addition to other health care or dental professionals that are involved with my medical and dental treatment that the following friends or family members have access to my dental records:

_____
Please list above the full names of family or friends

_____
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)

_____
_____
_____

* You may refuse to Sign this Acknowledgement *

Notice of Our Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL 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.

Our Legal Duty- We are required by applicable federal and state laws to maintain the privacy of your protected health/dental information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health/dental information. We must follow the privacy practices that are described 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 that 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 protected health/dental information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised 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 Protected Health Information

We will use and disclose your protected health/dental information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health/dental care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health/dental information to provide, coordinate or manage your health/dental care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/dental information, as necessary, to a home health agency that provides care to you. We will also disclose protected health/dental information to other physicians, oral surgeons, orthodontists, pedodontists, periodontists or endodontists who may be treating you. For example, your protected health/dental information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health/dental information from time to time to another doctor or health care provider (e.g., a specialist or laboratory) who, at the request of Dr. James C. Tauschek, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your doctor.

Payment: Your protected health/dental information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health/dental insurance plan may undertake before it approves or pays for the health/dental care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health/dental necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health/dental plan to obtain approval for the hospital admission.

Health/Dental Care Operations: We may use or disclose, as needed, your protected health/dental information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health/dental information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health/dental information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health/dental information, we will have a written contract that contains terms that will protect the privacy of your protected health/dental information.

We may use or disclose your protected health/dental information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health/dental information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health/dental information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health/dental 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. Without your written authorization, we will not disclose your health/dental care information except as described in this notice.

Others Involved in Your Health/dental Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health/dental information that directly relates to that person's involvement in your health/dental care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health/dental information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health/dental information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health/dental information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health/dental information for research purposes in limited circumstances. We may disclose the protected health/dental information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health/dental information to the extent necessary to avert a serious and imminent threat to your health/dental or safety, or the health or safety of others. We may disclose your protected health/dental information to a government agency authorized

to oversee the health/dental care system or government programs or its contractors, and to public health authorities for public health purposes.
Health Oversight: We may disclose protected health/dental information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health/dental information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health/dental information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose your protected health/dental information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health/dental information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health/dental information if it is necessary for law enforcement authorities to identify or apprehend an individual.
Required by Law: We may use or disclose your protected health/dental information when we are required to do so by law. For example, we must disclose your protected health/dental information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health/dental information when authorized by workers' compensation or similar laws.
Process and Proceedings: We may disclose your protected health/dental information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health/dental information to law enforcement officials.
Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health/dental information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health/dental information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health/dental information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
Patient Rights-Access: You have the right to look at or get copies of your protected health/dental information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health/dental information. 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 $25.00 for each page or $10.00 per hour to locate and copy your protected health/dental information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health/dental information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health/dental information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health/dental information, a description of the protected health/dental information we disclosed, the reason for the disclosure, and certain other information. If you request this list 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 a full explanation of our fee structure.
Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health/dental 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. We will not be bound unless our agreement is so memorialized in writing.
Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health/dental information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.
Amendment: You have the right to request that we amend your protected health/dental information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.
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. Please contact us using the information listed at the end of this notice to obtain 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 using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health/dental information or in response to a request you made, you may complain to us using the contact information 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 protect the privacy of your protected health/dental 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

Office Contact Person: Dr. James Tauschek, Telephone: (608)848-5680, Address: 6627 Mc Kee Rd, Madison, WI 53719

MEDICAL HISTORY

Patient's Last Name_____ First Name_____ M.I._____ Date of Birth_____

1. Medical Doctor's Name_____
   Address_____ Phone (___)_____
2. Are you under a physician's care at this time? ..... Yes No
   Since When_____ Why?_____
3. When was your last complete physical exam?_____
4. Are you taking any medications or health related substances? Yes No (If yes, please list in comments)
5. Do you have any allergies? ..... Yes No
   ◯ Medications_____ ◯ Environmental_____
6. Do you use birth control medications? ..... Yes No (If yes, please list in comments)
7. Are you pregnant or suspect you may be? ..... Yes No ..... Expected Due Date_____
8. Do you have any problems with antibiotics, anesthetics or other medications? ..... Yes No
   a. If yes, explain_____
9. Do you react negatively to metals or latex? ..... Yes No
10. Do you have any of the following?
    ◯ Pace maker ◯ Artificial heart valve implant ◯ Heart disease
    ◯ Rheumatic fever ◯ Heart murmur ◯ Other_____
11. Do you have high or low blood pressure? ..... Yes No
    a. If yes, how is it controlled_____
12. Have you ever had a major surgery or illness? ..... Yes No
    a. If yes, explain_____
13. Have you ever been treated with:
    ◯ Radiation treatment ◯ Chemotherapy treatment
14. Do you have an artificial joint or prosthesis? ..... Yes No
    a. If yes, please explain_____
15. Do you have any blood disorders such as anemia, leukemia, etc? ..... Yes No
    a. If yes, please explain_____
16. Have you been diagnosed with:
    ◯ GERD ◯ Acid Reflux ◯ Other stomach problems
17. Do you ever have cold sores or herpes? ..... Yes No ..... If yes, how often?_____
18. Have you had any problems or disorders with your liver? ..... Yes No
19. Do you have diabetes? ..... Yes No ..... If yes, Type I or Type II
20. Do you have asthma? ..... Yes No ..... Do you carry an inhaler? Yes No
21. Do you have epilepsy or seizure disorders? ..... Yes No ..... Date of last seizure?_____
22. Have you ever tested positive for HIV or AIDS? ..... Yes No
23. Have you had or do you test positive for hepatitis? ..... Yes No ..... If yes, A B C
24. Do you have or have you ever tested positive for Tuberculosis (T.B.)? ..... Yes No
25. Have you been diagnosed with LD, ED, CD, ADHA or ADD? ..... Yes No
    If yes, what is the best form for patient consultation ..... verbal written
26. Do you use tobacco? ..... Yes No ..... If yes, How much?_____ How many years?_____ What form?_____
27. How many alcoholic beverages do you consume per week?_____
28. Do you have a history of chemical dependency? ..... Yes No If yes, how long have you been in recovery?_____
29. Do you habitually use controlled substances? ..... Yes No If yes, when was the last time?_____
30. Have you taken Cocaine, Ecstasy or Methamphetamine in the past 24 hours? ..... Yes No
31. Please list anything else not covered in this form that we should know about your health._____

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

DENTAL HISTORY

Patient's Last Name _____ First Name _____ M.I. _____ Date of Birth _____

1. How long since your last dental visit?_____
2. What was done at that time?_____
3. Previous dentist's name _____
   Address: _____ Phone (___) _____
4. Why have you scheduled today? ○ Check up ○ Dental pain ○ Other(explain)_____
5. When was the last time your teeth were cleaned?_____
6. Have you made regular dental visits? ..... Yes or No
   How often? _____
7. Were dental x-rays taken at your last visit? ..... Yes or No
8. Have you lost any teeth or have you had any teeth removed? ..... Yes or No
   Why? _____
9. Have they been replaced? ..... Yes or No
   a. If yes, how have they been replaced?
      - ○ Implant When _____
      - ○ Fixed Bridge When _____
      - ○ Removable Appliance When _____
      - ○ Denture When _____
   b. If no, would you like to know about permanent replacements? ..... Yes or No
10. Are you unhappy with the replacement? ..... Yes or No
    a. If yes, explain _____
11. Have you ever had problems or complications with previous dental treatment? ..... Yes or No
    a. If yes, explain _____
12. Do you clench or grind your teeth? ..... Yes or No
    a. If yes, do you have/wear a guard at night or throughout the day? ..... Yes or No
13. Does your jaw pop or click? ..... Yes or No ..... How often? _____
14. Do you have pain or soreness in the muscles around your face or ear? ..... Yes or No
    a. If yes, how often? _____
15. Does food get caught in your teeth? ..... Yes or No
    a. If yes, in what area? _____
16. Are your teeth sensitive to: ○ Hot ○ Cold ○ Pressure ○ Sweets
17. Do your gums bleed or hurt? ..... Yes or No
    a. If yes, when? _____
18. How often do you brush your teeth? _____ When? _____
19. Do you use dental floss? ..... Yes or No ..... How often? _____
20. Are you unhappy with the appearance of your teeth? ..... Yes or No
    a. If yes, explain _____
21. Is your breath offensive at times? ..... Yes or No ..... When? _____
22. Have you ever had periodontal (gum) surgery? ..... Yes or No
    a. Where? _____
    b. When? _____
23. Have you had orthodontic (braces or retainers) work? ..... Yes or No
24. Do you have anything that you do not like about dental appointments? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE _____

DENTIST'S SIGNATURE_____ DATE _____

Maple Grove Dental S.C. Financial Policy

Thank You for choosing Maple Grove Dental S.C. We are committed to providing excellent dental care for you. As part of our service to you, and in an effort to contain ever-rising health costs while maintaining our high quality service, we have implemented the following financial policy. To assure all patients remain informed we require you to read and sign this copy prior to dental service. If you have any questions, please let us know. **Thank You!**

Payment options if you have *no* insurance:

1. You may pay by cash, check, or bank card on the day of service.
2. Treatment involving lab fees (crowns, bridges, implants or dentures, etc.) requires ½ of the fee when scheduling treatment and the other ½ at the start of treatment.
3. We offer financing through Care Credit. Approval through Care Credit offers a variety of payment plans including some with interest free options.

Payment options if you have insurance:

1. _____You choose to pay your deductible and any out-of-pocket expenses at the time services are rendered by cash, check, or bank card.
2. _____You choose to pay all your treatment by cash, check, or credit card at the time of service. We will request your insurance carrier send their payment directly to you.
3. Treatment involving lab fees (crowns, bridges, implants or dentures, etc.) you must pay ½ of your patient portion when scheduling the treatment and ½ at the first appointment starting the treatment. Your remaining balance will be due after receipt of benefits from your insurance company.
4. We offer financing through Care Credit. Approval through Care Credit offers a variety of payment plans including some with interest free options.

Dental Insurance: Your insurance coverage is a contract between you and your carrier. As a courtesy, the office submits claims to your insurance carriers, but you are responsible for 100% of any charges. Typically we will wait for payment from your insurer, but you must personally pay any claims that are unpaid or partially paid by your insurer. All balances are due and payable upon receipt of statement.

Broken Appointments/ Short notice Cancellation: The third time a patient does not show for an appointment or cancels with less than **24 hour** notice; there will be a charge of $10.00 per 10 minutes reserved appointment time. This must be paid before any future appointments are scheduled.

Returned checks: Any returned check fees will be the responsibility of the patient. In addition we will charge $25.00 plus the fees incurred for your returned check.

Discounts: Applied only to non- insurance reimbursed procedures.

1. 5% discount for payment in full on day of scheduling if paying with cash or check.
2. 3% discount for payment in full on day of scheduling if paying with credit card.

Minor patients: Parents must accompany minor patients to their first appointments. Non-emergency treatment may be denied for unaccompanied minors, unless prior parental permission for treatment, payment arrangements and medical history updates have been made.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be responsible for those treatment fees. If the divorce decree requires the other parent to pay all or part of the treatment fees, it shall be the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts: If your account has a balance that is 90+ days overdue, it will be sent to collections, unless prior arrangements have been made. If your account goes to the collection agency or lawyer, you agree to pay any of the collection costs incurred to collect the amount due from you. In case of suit, you agree the venue shall be Dane County, WI.

Patient's name (Please Print): _____ **Date:** _____

Responsible Party: _____ **Signature:** _____

Covid-19 Pandemic- Patient disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstances of your health.

A weak or compromised immune system (including but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any prior or current disease or medical condition), can put you at higher risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

Do you have a fever or an above normal temperature?	Yes	No
Have you experienced shortness of breath or had trouble breathing?	Yes	No
Do you have a dry cough?	Yes	No
Have you recently lost or had a reduction in your sense of smell or taste?	Yes	No
Do you have a sore throat?	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	Yes	No
If yes, when? _____		
Have you tested positive for COVID-19?	Yes	No
If yes, when? _____		
Have you been tested for COVID-19 and are awaiting the results?	Yes	No
If yes, when?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?	Yes	No
Have you traveled within the United States by air, bus or train within the past 14 days?	Yes	No

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document. I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date