PATIENT MEDICAL HISTORY

Date: _____

Patient's Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Date of Birth _____ Sex_____

How did you hear about us? Check all that apply:

- ☐ Current/Former patient
  Their name: _____
- ☐ Drive-by
- ☐ Insurance company
- ☐ Google Search
- ☐ Facebook
- ☐ Madison.com
- ☐ Other: _____

DO YOU HAVE, HAVE YOU HAD, OR BEEN TREATED FOR ANY OF THE FOLLOWING:

Circle Answer(s)

Yes	No	Arthritis	Yes	No	Anorexia, Bulimia
Yes	No	Blood Disorder	Yes	No	Asthma
Yes	No	Heart Problems	Yes	No	Thyroid Condition
Yes	No	High Blood Pressure	Yes	No	Sexually Transmitted Disease
Yes	No	Low Blood Pressure	Yes	No	AIDS or HIV Infection
Yes	No	Epilepsy, Seizures	Yes	No	Heart Murmur. Premed Necessary? _____
Yes	No	Fainting Spells	Yes	No	Pacemaker. Type _____
Yes	No	Tuberculosis	Yes	No	Joint Replacement. Premed Necessary? _____
Yes	No	Diabetes (circle one) Type 1 Type 2	Yes	No	Radiation or Chemotherapy. Date _____
Yes	No	Hepatitis, Jaundice, Liver Disease	Yes	No	Ulcers
Yes	No	Kidney Disorder	Yes	No	Frequent Headaches
Yes	No	Chronic Sinus	Yes	No	Osteoporosis
Yes	No	Are you pregnant? Due Date _____			

Please describe any illness or condition not mentioned above

_____

Yes No Have you ever had an allergic reaction or been told not to take any medications? If yes, describe.

_____

Please list your current medications (including birth control, vitamins, aspirin, etc.)

_____

Yes	No	Are you a recovering alcoholic?	Yes	No	Do you use smokeless tobacco (chew)?
Yes	No	Do you smoke?	Yes	No	Are you allergic to Latex?

Date of last medical exam _____

Physician's Name or Clinic _____ Phone No. _____

Continued

Dental History

Purpose of initial visit _____

Are you pleased with the appearance with your teeth? _____

Are you experiencing any pain or discomfort? _____

How long has it been since your last dental visit? _____

What was done at that time? _____

Who was your last dental provider? _____

Do you have any teeth that are sensitive to hot, cold, sweets, or pressure? _____

Have you had any periodontal treatment done (gum therapy)? _____

Do you have bad breath or taste? _____ Do your gums bleed? _____How often do you floss? _____

Any unfavorable dental experience? _____

Do you experience pain, popping of the jaw, or unusual sounds around the ear while eating? _____

Do you snore or have been told that you snore? _____

Have you had a polysomnogram (Sleep Center Test)? _____ Cardiac Stress Test? _____

Do you use a CPAP or other device? _____ If yes, type of device _____

Are there any questions or concerns you would like to address that are not listed above?

_____

For Children

Is this their first dental visit? _____

Do you use well water, city water, or bottled water? _____

Does your child use any fluoride supplements? _____ Do they have a finger sucking habit? _____

Does your child have any special needs that we should be aware of?

_____

Please list any recommendations that would assist us with treating your child.

_____

_____

Patient/Parent or Guardian Signature

_____ _____

Dentist Signature Dentist Print

PATIENT INFORMATION (CONFIDENTIAL)

Date _____ Patient's Name _____ Date of Birth _____

Please check one: ☐ Minor ☐ Single ☐ Married Social Security # _____

Emergency Contact Person: Name _____ Phone # _____

☐ Check if information is same as above **RESPONSIBLE PARTY**

Name of person responsible for this account _____ Relationship to Patient_____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Home Phone _____ Cell Phone _____

INSURANCE INFORMATION (PRIMARY INSURANCE)

Name of Policy Holder _____ Relationship to Patient _____

Date of Birth _____ Employer _____ Work Phone _____

Name of Insurance Company _____ Insurance Phone Number _____

Group Number _____ Member/Subscriber Number _____

DO YOU HAVE ADDITIONAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURANCE INFORMATION (SECONDARY INSURANCE)

Name of Policy Holder _____ Relationship to Patient _____

Date of Birth _____ Employer _____ Work Phone _____

Name of Insurance Company _____ Insurance Phone Number _____

Group Number _____ Member/Subscriber Number _____

- ☐ I authorize release of any information concerning my/my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.
- ☐ I authorize payment of insurance benefits directly to Parkview Dental Associates.
- ☐ I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- ☐ I understand that I am responsible for and agree to pay the total fees for my/my children's dental treatment.
- ☐ I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date dental services are rendered.
- ☐ I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have insurance benefits.

Patient and/or Guardian Signature _____

Date _____

Parkview Dental Associates, SC
Financial Policy Acknowledgment

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, Mastercard, and Discover. We also partnered with Care Credit to offer the flexibility of deferred interest and extended payment options. Check policy: If your check is returned for any reason, you will be charged $25.00 for processing fees. All accounts with an outstanding balance 60 days past the date of service, including those with financial arrangements, are subject to a 1.5% interest charge monthly.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality of dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense. We are participating providers in the Delta Dental, Liberty, Cigna, ADP, Momentum, WEA, Humana PPO, and Alliance plans including Aetna, United Concordia, Assurant, and Dental Health Alliance; however, we do not participate in any other PPO network plans at this time.

Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

Important Facts About your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have (i.e, Traditional, PPO, Premier, or DMO), and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered.

Patient/Parent/Guardian Signature:_____ Date:_____

CANCELLATION POLICY

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, ***we require a 24-hour notice of cancellation for all appointments***. **Appointments cancelled with less than a 24-hour notice, including no-shows, will be subject to a conditionally refundable deposit required at the time the appointment is scheduled. Deposits required: $30 for hygiene and $50 for dental treatment.** Repeat cancellations may result in forfeited deposit and/or dismissal from the practice at the discretion of the doctor. _____ (initials)

Revised 10/26/23

Parkview Dental Associate, SC
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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 complain to us using the contact information listed at the end of this Notice. 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.

Our Privacy Official: Jennifer Whetstone

Telephone: 608-837-7394 Fax: 608-825-3324

Address: 601 N Thompson Road, Sun Prairie, WI 53590

E-mail: jwhetstone@parkviewdental.us

Parkview Dental Associates, SC
Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

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)

PARKVIEW DENTAL
ASSOCIATES

SUBSTITUTED CONSENT FOR TREATMENT OF MINORS AND INCOMPETENTS

I, the undersigned parent/guardian of _____, in the event that I cannot be contacted through reasonable efforts, hereby empower and grant to _____ permission to consent and authorize dental treatment for my above named minor child/ward. This authorization shall be valid for the period of time commencing on _____ and ending on the minor child's 18th birthday.

I do hereby indemnify and hold harmless Parkview Dental Associates, the doctors, hygienists, assistants, and any other persons who act in reliance upon this authorization.

Executed this _____ day of _____ , 20_____.

_____

Parent/Guardian Signature

Parent/Guardian can be located at the following address/phone number/email:

_____

_____

Minor child/ward's known allergies:

_____

_____