Mueller-Graber DENTAL

Date:

NEW PATIENT FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.)	**DOB**	**SEX** ☐ Male ☐ Female ☐ Other
Marital status ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor		
How did you hear about us?		

CONTACT INFORMATION			
Street Address			
City		**State**	**Zip**
Phone numbers	**Home**	**Cell**	
	Work	**Other**	
Email			
Divers License Number			
Social Security Number			
Other family members at Mueller Dental			
Method of Payment ☐ Insurance ☐ Cash ☐ Credit Card			
Patient/Parent Employer			
Present position			
How long held? ☐ month(s) ☐ year(s)			
Business Address			
City		**State**	**Zip**
Spouse/Parent Name			
Spouse/Parent Employer			
Present position			
How long held? ☐ month(s) ☐ year(s)			
Business Address			
City		**State**	**Zip**

EMERGENCY CONTACT	
Name	
Relationship	**Phone number**

DENTAL INSURANCE 1st COVERAGE		
Employee Name		
Date of Birth		
Relationship to patient		
Employer name		
Name of Insurance Co		
Address		
City	**State**	**Zip**
Phone number		
Program or policy #		
Social Security Number		
Union Local or Group		

DENTAL INSURANCE 2nd COVERAGE		
Employee Name		
Date of Birth		
Relationship to patient		
Employer name		
Name of Insurance Co		
Address		
City	**State**	**Zip**
Phone number		
Program or policy #		
Social Security Number		
Union Local or Group		

CONSENT I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and healthcare operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care _____.
My consent to disclosure of records shall be effective until I revoke it in writing.
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 payor of benefits may pay less than the actual bill for services, and that I am financial responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreement to the contrary and agree to be responsible for payment of services not paid by my dental care payor.
I attest to the accuracy of the information on this page.
Patient's or Guardian's signature_____ **Date** _____

Mueller-Graber DENTAL

Patient's Name _____/___/____
Last First M.I. DOB

DENTAL HISTORY FORM

Purpose of your initial visit		Comments
Are you aware of any problem(s)?		
Previous dentist name and address		
How long since your last dental visit?	☐ month(s) ☐ year(s)	
What was done at that visit?		
When was the last time your teeth were cleaned?		
Have you had regular visits?	☐ yes ☐ no ☐ don't know	
How often?		
Were dental x-rays done?	☐ yes ☐ no ☐ don't know	
Have you lost any teeth or have any teeth been removed?	☐ yes ☐ no ☐ don't know	
Why?		
Have they been replaced?	☐ yes ☐ no ☐ don't know	
How have they been replaced?		
Fixed Bridge Age / Removable Denture Age	Denture Age / Implant Age	
Are you unhappy with the replacement?	☐ yes ☐ no ☐ don't know	
If yes, explain		
Would you like to know about permanent replacements?	☐ yes ☐ no ☐ don't know	
Have you ever had problems or complications with previous dental treatment?	☐ yes ☐ no ☐ don't know	
If yes, please explain		
Do you clench or grind your teeth?	☐ yes ☐ no ☐ don't know	
Does your jaw click or pop?	☐ yes ☐ no ☐ don't know	
Have you experienced any pain or soreness in the muscles of your face or around your ear?	☐ yes ☐ no ☐ don't know	
Do you have frequent headaches, neckaches or shoulder aches?	☐ yes ☐ no ☐ don't know	
Does food get caught in your teeth?	☐ yes ☐ no ☐ don't know	
Are any of your teeth sensitive to	☐ Hot ? ☐ Cold? ☐ Sweets? ☐ Pressure?	
Do your gums hurt or bleed?	☐ yes ☐ no ☐ don't know	
Why?		
Do you experience dry mouth?	☐ yes ☐ no ☐ don't know	
How often do you brush your teeth?	**When?**	
Do you use dental floss?	☐ yes ☐ no ☐ don't know	
How often?		
Are any of your teeth loose, tipped, shifted or chipped?	☐ yes ☐ no ☐ don't know	
Are you unhappy with the appearance of your teeth?	☐ yes ☐ no ☐ don't know	
How do you feel about your teeth in general?		
Do you feel your breath is offensive at times?	☐ yes ☐ no ☐ don't know	
Have you ever had gum treatment or surgery?	☐ yes ☐ no ☐ don't know	
What?		
Where?		
When?		
Have you ever had orthodontic work?	☐ yes ☐ no ☐ don't know	
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?		
Do you have any questions or concerns?	☐ yes ☐ no ☐ don't know	

I certify that the above information is complete and accurate

Patient's/Guardian's signature _____ Date ____/_____/_____

Dentist's signature _____ Date ____/_____/_____

Mueller-Graber DENTAL **Patient's Name** _____/___/____
Last First M.I. DOB

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

		If yes, please explain here
Are you under a physician's care now?	☐ yes ☐ no	
Have you ever been hospitalized or had a major operation?	☐ yes ☐ no	
Have you ever had a serious head or neck injury?	☐ yes ☐ no	
Are you taking any medications, pills, drugs or vitamins?	☐ yes ☐ no	
Do you take, of have you taken, Phen-Fen or Redux?	☐ yes ☐ no	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ yes ☐ no	
Are you on a special diet?	☐ yes ☐ no	
Do you use tobacco?	☐ yes ☐ no	
Do you use controlled substances?	☐ yes ☐ no	

WOMEN: are you ... ☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐ Aspirin ☐Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other allergies:

Do you have, or have you had, any of the following?

AIDS/HIV positive	▫ yes ▫ no	Diabetes	▫ yes ▫ no	Hemophilia	▫ yes ▫ no	Radiation treatment	▫ yes ▫ no
Alzheimer's disease	▫ yes ▫ no	Drug addiction	▫ yes ▫ no	Hepatitis A, B or C	▫ yes ▫ no	Renal dialysis	▫ yes ▫ no
Anaphylaxis	▫ yes ▫ no	Easily winded	▫ yes ▫ no	Herpes	▫ yes ▫ no	Rheumatic fever	▫ yes ▫ no
Anemia	▫ yes ▫ no	Emphysema/COPD	▫ yes ▫ no	High blood pressure	▫ yes ▫ no	Rheumatism	▫ yes ▫ no
Angina	▫ yes ▫ no	Epilepsy/seizures	▫ yes ▫ no	High cholesterol	▫ yes ▫ no	Seasonal allergies	▫ yes ▫ no
Arthritis/Gout	▫ yes ▫ no	Excessive bleeding	▫ yes ▫ no	HPV/genital warts	▫ yes ▫ no	Shingles	▫ yes ▫ no
Artificial heart valve	▫ yes ▫ no	Excessive thirst	▫ yes ▫ no	Hypoglycemia	▫ yes ▫ no	Sinus trouble	▫ yes ▫ no
Artificial joint	▫ yes ▫ no	Fainting spells/dizziness	▫ yes ▫ no	Irregular heartbeat	▫ yes ▫ no	Spina bifida	▫ yes ▫ no
Asthma	▫ yes ▫ no	Fibromyalgia	▫ yes ▫ no	Kidney problems	▫ yes ▫ no	Stents/shunts	▫ yes ▫ no
Autism spectrum	▫ yes ▫ no	Frequent cough	▫ yes ▫ no	Liver disease/jaundice	▫ yes ▫ no	Stomach/Intestinal disease	▫ yes ▫ no
Blood disease	▫ yes ▫ no	Frequent headaches	▫ yes ▫ no	Low blood pressure	▫ yes ▫ no	Stroke	▫ yes ▫ no
Blood transfusion	▫ yes ▫ no	Genital herpes	▫ yes ▫ no	Lung disease	▫ yes ▫ no	Thyroid disease	▫ yes ▫ no
Breathing problems	▫ yes ▫ no	Glaucoma	▫ yes ▫ no	Mental illness	▫ yes ▫ no	Tonsillitis	▫ yes ▫ no
Cancer	▫ yes ▫ no	Hay fever	▫ yes ▫ no	Mitral valve prolapse	▫ yes ▫ no	Tuberculosis	▫ yes ▫ no
Chemotherapy	▫ yes ▫ no	Hearing impaired	▫ yes ▫ no	Osteoporosis	▫ yes ▫ no	Tumors or growths	▫ yes ▫ no
Chest pains	▫ yes ▫ no	Heart attack/failure	▫ yes ▫ no	Pacemaker	▫ yes ▫ no	Ulcers	▫ yes ▫ no
Cold sores/Fever blisters	▫ yes ▫ no	Heart murmur	▫ yes ▫ no	Parathyroid disease	▫ yes ▫ no	Venereal disease	▫ yes ▫ no
Congenital heart disorder	▫ yes ▫ no	Heart trouble/disease	▫ yes ▫ no	Parkinson's disease	▫ yes ▫ no	Vision impaired	▫ yes ▫ no

Have you ever had any serious illness not listed above? ☐ yes ☐ no

If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's/Guardian's signature _____ Date ____/_____/_____

Mueller-Graber DENTAL

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 your 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 4/16/2003 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 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.

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 or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use or 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason expect those described in this Notice.

To your family and friends: we must disclose your health information to you, as describe din 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 your 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 use or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment 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 of 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 reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). IF this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

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 end of this Notice. We will chage you a reasonable cost-based fee for expenses such as copies and staff 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 may charge you for each page, 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 instance 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 the alternative means or locations, and provide satisfactory explanation how payment 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy 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 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 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 chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Laura Larson
Telephone:(608) 835-0900 Fax: (608) 835-3690 E-mail: manager@muellerdental.com
Address: 152 Alpine Parkway, Oregon, WI 53575

ADDENDUM TO NOTICE OF PRIVACY PRACTICES

This addendum to the notice of privacy practices sets forth Wisconsin privacy requirements that are in addition to those in our notice of privacy practices.
Please review it carefully. The privacy of your health information is important to us.

We are required by Wisconsin law to maintain the privacy of your health information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Healthcare operations: Under Wisconsin law, we must have your written permission before we may use and disclose your health information in connection with healthcare operations other than committees and review organizations.

To your family and friends and persons involved in your care: Under Wisconsin law, we must have your written permission before we may disclose your health information, other than limited identifying information, to your family, friends, or other persons involved in your care.

Abuse or Neglect: Under Wisconsin law, we must have your written permission before we may disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence of other crimes. We may report child abuse and the abuse or neglect of vulnerable adult as allowed by Wisconsin law.

PATIENT RIGHTS

Restriction: While we are allowed to determine where we agree to your request to restrict our use and disclosure of your protected health information, Wisconsin law requires that we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.

Contact Officer: Laura Larson
Telephone:(608) 835-0900 Fax: (608) 835-3690 E-mail: manager@muellerdental.com
Address: 152 Alpine Parkway, Oregon, WI 53575

Mueller-Graber DENTAL

152 Alpine Parkway • Oregon, WI 53575 • (608) 835-0900 • MuellerDental.com

Chad T. Mueller, D.D.S.

ACKNOWLEDGMENT 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.

Name *(Please Print)*: _____

Signature: _____ Date: _____

Office Representative: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other *(Please Specify)*

_____

_____

_____

_____

Mueller-Graber DENTAL

152 Alpine Parkway • Oregon, WI 53575 • (608) 835-0900 • MuellerDental.com

Chad T. Mueller, D.D.S.

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 from above):* _____

Address: _____ **Phone:** _____

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 persons, 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 judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick of filled prescriptions, medical/dental supplies, x-rays, and 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.

SECTION C: Revocation

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at anytime by giving written notice of revocation to the Contact Officer 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 Officer: Laura Larson **Phone:** 608-835-0900 **Address:** 152 Alpine Parkway • Oregon, WI 53575

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 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's Name **Relationship to Individual**

PLEASE FORWARD TO YOUR PREVIOUS DENTIST

I authorize the release of my dental records to:

Mueller Dental

152 Alpine Parkway

Oregon, WI 53575

(608)835-0900

E-mail radiographs to: info@muellerdental.com

Name (print) _____

_____

_____

Signature: _____