NEW PATIENT REGISTRATION

Patient Name (First, Middle, Last): ____________________

Prefers to be called: ____________________

Address (Street, City, State, Zip): ____________________

Home Phone: ____________ Cell: ____________ Email: ____________

Birthdate: ________ Age: ______ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Social Security #: ____________ Employer's/School Name: ____________

Occupation: ____________ Work Phone: ____________ OK to call work? ❑ Yes ❑ No

Is another member of your family a patient at our office? Name: ____________

Relationship: ____________ Who can we thank for referring you to us?: ____________

Emergency Contact (outside your home): ____________

Relationship: ____________ Work#: ____________ Home/Cell: ____________

Person Financially Responsible (If Other than Yourself): Name (First, Middle, Last): ____________

Relationship: ____________ Social Security #: ____________ Home/Cell: ____________

Spouse Name: ____________ Spouse Occupation: ____________

Spouse Employer: ____________ Work Phone: ____________ OK to call work? ❑ Yes ❑ No

Do you have Dental Insurance? ❑ Yes ❑ No (*We will ask for a copy of your insurance card(s) to keep on file.*)

PLEASE INITIAL

______ *I authorize the dentist to release all information to secure the payment of benefits.*

______ *I understand that I am financially responsible for all charges whether or not paid by insurance.*

APPOINTMENTS:

We value your time. Please value ours. We request 48 hour advance notification when possible, for any appointment changes.

FINANCIAL POLICY:

Because we care about your dental health, we offer choices for paying for your dental care. We accept the following forms of payment: Cash, Checks, Credit/Debit card and Third Party Financing (if approved).

We can help with discounts:

7% discount if paid by cash or check at time of scheduling.

4% discount if paid by credit card at time of scheduling.

Insurance Policy - All insurance co-pays and deductibles must be paid at or before the time of service. We will submit all pertinent information electronically to your insurance company and help you to maximize your dental benefits while receiving your individualized dental care. In the event we do not receive payment from your insurance company within 60 days the balance will be required to be paid by you.

One Less Bill - We would like to retain your credit card on our secure portal for any charges less than $100.00 to be automatically processed. You will receive an itemized receipt with explanation of the charges and amounts due. This means one less bill coming to your home.

PLEASE COMPLETE BOTH SIDES OF FORM >

FINANCIAL POLICY CONTINUED:

CARD NUMBER: ______________________________ **EXPIRATION:**_____________ **SIGNATURE**____

PLEASE INITIAL __________ *I have read and understand the financial options available to me, the account holder.*

ACCOUNT HOLDER SIGNATURE: ____ **DATE:**________________________

MEMBERS OF MY FAMILY THIS AUTHORIZATION APPLIES TO:____

PLEASE INITIAL

ACKNOWLEDGEMENTS AND CONSENT FOR TREATMENT:

_______ *I have read and acknowledge the above Financial Policy.*

_______ *I authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.*

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

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

_______ *I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.*

_______ *I give consent to the doctor's or designated staff's use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care options.*

_______ *I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.*

SIGNATURE:____

DATE:____

PARENT/RESPONSIBLE PARTY'S SIGNATURE:____

RELATIONSHIP TO PATIENT:____

Patient Name: ______________________ Date of Birth: ______________

Physician's Name: ______________________ Physician's Phone #: ______________

Purpose of last physician visit: ______________________

Last physician visit: ______________________ General health? o Poor o Fair o Good

Last dental exam: ______________________ Any immediate concerns? o Yes o No

YES	NO		DIAGNOSIS DATE
ALLERGIC REACTION QUESTIONS:			
o	o	Penicillin or other antibiotics	________
o	o	Aspirin or Ibuprofen	________
o	o	Tetracycline	________
o	o	Codeine or sedatives	________
o	o	Latex	________
o	o	Other medications ______________________	
MEDICAL HISTORY CONDITIONS:			
o	o	Antibiotics before dental treatment due to joint replacement(s) or heart murmur.	________
o	o	Artificial joints (hip, knee, etc.)	________
o	o	Heart (Surgery, Disease, Attack)	________
o	o	Congenital heart problems	________
o	o	Heart murmur	________
o	o	High blood pressure: Level/date:	________
o	o	Low blood pressure: Level/date:	________
o	o	Stroke	________
o	o	High cholesterol	________
o	o	Anemia or other blood disorder	________
o	o	Prolonged bleeding due to a cut	________
o	o	Lung or breathing problems	________
o	o	Tuberculosis	
o	o	Sinus problems	________
o	o	Asthma/COPD	________
o	o	Hives or skin rash	________
o	o	Multiple Sclerosis	________
o	o	Neuro-muscular disease	________
o	o	Osteoporosis or bone disorders	________
o	o	Hepatitis or liver disease	________
o	o	Kidney disease	________
o	o	Thyroid or parathyroid problems	________

YES	NO		DIAGNOSIS DATE
o	o	Stomach Problems	________
o	o	Diabetes (Insulin / Diet Controlled)	________
o	o	Arthritis	________
o	o	Head or neck injuries	________
o	o	Epilepsy, convulsions (seizures)	________
o	o	Cold sores / fever blisters	________
o	o	AIDS or HIV infection	________
o	o	Sexually transmitted disease	________
o	o	Cancer/chemotherapy/radiation	________
o	o	Depression	________
o	o	Anxiety	________
o	o	Alcohol / drug dependency	________
o	o	Glaucoma or eye problems	________
o	o	Hearing problems	________
		Special Needs: ______________________	
o	o	Sleep Apnea	________
o	o	Currently pregnant	________
o	o	Are you a smoker? Packs per day:	________
o	o	Do you use smokeless tobacco?	
DENTAL HISTORY QUESTIONS:			
o	o	Is there anything you would like to change about your teeth or your smile? ______________________	
o	o	Do you wear any of the following? o Dentures o Partials o Orthotic o Night Guard	
o	o	Have you had orthodontic treatment?	
HAVE YOU EXPERIENCED THE FOLLOWING:			
o	o	Clenching or grinding your teeth	
o	o	Headaches	
o	o	Dry Mouth	
o	o	Bleeding Gums	

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

____

____

List ALL medications: ____

____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, I give my permission to ask the respective health care provider of agency, who may release such information to you.

PATIENT/RESPONSIBLE PARTY'S SIGNATURE: ______________________ **DATE:** ______________

PLEASE UPDATE PATIENT CONTACT INFORMATION ALONG WITH HEALTH HISTORY

Side 1

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 our 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 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 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 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 ay 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 the 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 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 disclose your health information when we are required to do so by law.

Side 2

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 institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstance.

Appointment Reminders: We may use or disclose your health information to provide you with an appointment reminder (such as voicemail 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 practically 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 charge 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 will charge you $1.00 for each page, $0.00 per hour 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 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 at least 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.

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 explanations 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 (email), you are entitled to receive 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.

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 by 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.

CONTACT OFFICER: Kelly Bellinger

PATIENT ACKNOWLEDGMENT & CONSENT FORM

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Wisconsin Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature:____________________________________

Print Name:____**Date:** _____________________________

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

Patient Signature:____________________________________

Print Name:____**Date:** _____________________________

FOR OFFICE USE ONLY

____Patient Refused to Sign

The following circumstance prohibited the patient from signing the Acknowledgment:

____

An emergency situation prevented the patient from signing the Acknowledgment:

____

____ ____

Office Personnel Signature:____________________________________

Office Personnel Print Name:____**Date:** ____________________________

SLEEP APNEA
HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF INFORMATION

I UNDERSTAND:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand this consent/authorization may be revoked at any time except to the extent already acted upon.
- I have the right to revoke this authorization by sending a notice stopping this authorization to Sleep Healers at the address listed above. The Authorization will stop on the date my request is received.
- I understand if the organization I have authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that the person/organization receiving the information will be billed (subject to state law) a cost-based fee for costs associated with providing the requested information.

Last Name:______________________________ **First Name:** ______________________ **Middle Initial:** _____

Address:________________________________ **City:** ____________________ **State**:____ **Zip:**__________

Patient Signature:____ **Date:** ___________________

Authorized Representative: ____ Date: ___________________

(If other than the Patient) Relationship to Patient: _______________________________

I authorize the following information to be released from my record(s):
Date of Service: ALL Interpretive Report: ALL Other (specify): ALL SLEEP STUDY INTERPRETATIONS

Some medical records contain extremely confidential information. I consent to the release of the following information (if left blank, authorization is not assumed):

- Information relating to drug or alcohol abuse _____ (initials)***
- Information relating to mental health issues _____ (initials)***
- Information relating to HIV testing, infection status, or care or treatment of AIDS _____ (initials)***

Organization providing the information: Sleep Healers
Person/organization to receive the information

Name:____________________________________ Fax Number:_________________________

Address: ____

DESCRIPTION OF EACH PURPOSE FOR THE USE OR RELEASE OF THE INFORMATION:
(PROVIDE A DETAILED DESCRIPTION OF THE ACTIVITY FOR WHICH THE INFORMATION WILL BE USED)

____

____

____

____

This authorization for release of the above information to the above named persons/organizations will expire 90 days from the date of signature.