PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Emergency Contact _____

Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Child Dental History Form

Patient Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Parent/ Guardian Name: _____

PLEASE CIRCLE THE APPROPRIATE ANSWER

1) **Is this your child's first visit to the dentist? YES NO**
2) **If not, how long since their last visit? _____**
3) **Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO**
4) **Does your child eat between meals? YES NO**
5) **Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO**
6) **When does your child brush his/ her teeth?**
   - **a. Upon arising b. After eating any food c. Right after meals d. Before going to bed**
7) **How does your child receive fluoride?**
   - **a. Community water b. Well water c. Drops or tablets d. Rinse or gel e. No fluoride**
8) **Have any cavities been noted in the past? YES NO**
9) **Does your child suck his/ her thumb or fingers? YES NO**
10) **Were any teeth (baby or permanent) removed by extraction? YES NO**
    - **a. If so, was it suggested the space be maintained? YES NO**
    - **b. Was an appliance placed? YES NO**
11) **Has there ever been any injuries to the teeth, such as falls, blows, chips, etc.? YES NO**
    - **a. If so, please describe_____**
12) **Has your child has any problems with dental treatment in the past? YES NO**
13) **Has anyone in your family, including parents, had orthodontics? YES NO**
14) **Has your child ever received local anesthetic? YES NO**
15) **Has your child ever has occlusal sealants? YES NO**
16) **Does your child think there is anything wrong with his/ her teeth? YES NO**

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCUTATE.

Parent/ Guardian Signature: _____

Date: _____

Dentist Signature: _____

Date: _____

Time 9:56 AM

William J Twohig DDS

Date 1/9/2018

Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	
Do you require pre-medication prior to your dental appointment?	Yes No	If yes	
Are you taking any medications, pills, or drugs? Please List Below:	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? ☐ If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

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.

Signature of Patient, Parent or Guardian:

X

Date:_____

Dr. William J Twohig DDS
PO Box 579
Weyauwega, WI 54983
Phone: (920)867-3101

Office & Financial Policies

Appointments

One of our team members will notify you of your scheduled appointment 2 weeks prior to the date via email or text message. To receive this type appointment reminder, you must provide a valid email address, cell phone number, or both. For those patients that would prefer a phone call reminder for their upcoming appointment you will be notified 1 week prior. No matter your preferred method of contact, **ALL** appointments must be confirmed either by replying to your email or text message notification or by calling our office to verbally confirm your scheduled date and time. If you have a conflict with a scheduled appointment or are unable to make it to your scheduled appointment you must call the office to notify our staff. We ask that you do **NOT** notify us by email or by replying to our automated confirmation service as we may not receive the message in time.

We understand that sometimes things happen that would prevent you from being able to keep your scheduled appointment. But please keep in mind that when scheduling your appointment, that specific time is reserved only for you. If you are unable to keep your scheduled appointment we ask that you please notify us 48 hours prior to so that we may offer that appointment time to another patient. **Short notice cancelations (less than 48 hours) or No Shows may result in a missed appointment charge that ranges in fees of $75 to $150.** There are few exceptions to this policy but we do understand sudden illnesses and unforeseen situations.

We ask that patients with scheduled appointments please arrive 10 minutes prior to your scheduled appointment time. For patients that will be visiting us for the first time we ask that you arrive 20 minutes prior to your scheduled appointment time as there are a few forms that, by law, need to be completed upon your arrival at the office. If you know that you will be running late for your appointment we encourage you to please call our office and inform us of the situation. We reserve the right to reschedule your appointment if we feel that the appointments of other patients will be affected.

Insurance & Financials

Our dental practice works with most dental insurance plans; however, we are a non-contracted provider and encourage our patients to please familiarize themselves with their insurance plan. As a courtesy to our patients we will submit your insurance claim but it is your responsibility to follow up regarding benefit payments. Because we are a non-contracted provider some insurance plans do send the benefit payment to the policy holder.

We ask that payments for any and all services be made the day of your appointment. If we are submitting to your insurance provider we do expect the patient portion to be paid at the time services are rendered. Services that will not be covered by your insurance plan must be paid for that same day as well. We accept cash, check, all major credit cards, Care Credit and Lending Club. If you are unfamiliar with Care Credit or Lending Club one of our helpful team members would be happy to help answer your questions. We do not offer in house payment plans or financing.

Patient Name: _____
(Please Print)

Patient Signature: _____
(Signature of Patient, Parent, or Guardian)

Date: _____

Dr. William J Twohig DDS
PO Box 579
Weyauwega, WI 54983
Phone: (920)867-3101
Fax: (920)867-3108
Email: info@drtwohig.com

FINANCIAL OPTIONS

CASH, CHECK or CREDIT CARD, MASTERCARD, VISA, DISCOVER OR AMERICAN EXPRESS.
We accept these major credit cards to allow you the most convenience in taking care of your account.

PRE-PAYMENT OPTION.
Get a 5% Pre-Pay Discount on treatment totaling **$500 or more** if payment is received 7 days prior to your scheduled appointment. If selecting this option, **payment must be made by either CASH or Check.**

FOR PATIENTS WITH AN ACTIVE DENTAL INSURANCE POLICY.
To help you in maximizing your dental benefits, we'll gladly assist in submitting your dental claim forms to your primary dental insurance provider. However, please be advised we are an Out of Network dental provider and patient balances are due at the time services are rendered.

ACCEPTED & OFFERED OUTSIDE FINANCING OPTION.
For our patients that prefer to pay overtime, we've made special arrangements with our friends at **CARE CREDIT & LENDING CLUB**. Both entities have a variety of payment options that allow you to carry on with your dental care while making comfortable monthly payments. One of our team members will be happy to assist you with any questions.

DESIGNATED FINANCIAL OPTIONS

***If choosing to pay by Credit/ Debit Card, please fill in the information below.**
***If choosing to pay by Care Credit Card, please provide the below information and make sure to present your card at the time of service.**

☐ **CASH/ CHECK** ☐ **CARE CREDIT** ☐ **DISCOVER** ☐ **MASTERCARD** ☐ **VISA** ☐ **AMERICAN EXPRESS**

_____ _____
Card Number **Expiration Date**

I have read and understand my financial options. I understand that any and/or all expenses incurred must be paid for at the time services are rendered. I understand that my dental insurance claims, if applicable, will be submitted on my behalf but it is my responsibility to provide accurate and up to date insurance information prior to my scheduled appointment.

SIGNATURE: _____ **DATE:** _____

Dr. William J Twohig DDS
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of **William J. Twohig DDS**. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact **William J Twohig's** Privacy Official at:

ATTN: Nicole D
417 E. Ann Street
PO Box 597
Weyauwega, WI 54983
(920)867-3101
(920)867-3108
front2@drtwohig.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on **November 28, 2017**

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

- **Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
- **2. Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

- **3. Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
- **4. Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.
- **5. Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
- **6. Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.
- **7. Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

- **Disclosures Required by Law.** We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.
- **2. Public Health Activities.** We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **3. Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.
- **4. Health Oversight Activities.** We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.
- **5. Lawsuits and Legal Actions.** We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.
- **6. Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.
- **7. Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.
- **8. Organ, Eye and Tissue Donation.** We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.
- **9. Research Purposes.** We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.
- **10. Serious Threat to Health or Safety.** We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.
- **11. Specialized Government Functions.** We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

PEDIATRIC/ADOLESCENT SLEEP QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Please place a checkmark next to all statements that apply.

While Sleeping, Does Your Child:

_____ Snore more than half the time

_____ Always snore

_____ Have heavy or loud breathing

_____ Snore loudly

_____ Have trouble breathing or struggles to breathe

_____ ever stop breathing at night

Does Your Child…?:

_____ Tend to breathe through the mouth during the day

_____ Have a dry mouth upon waking up in the morning

_____ occasionally wet the bed

_____ Grind his/her teeth while sleeping

_____ Have any bite problems or crowded teeth

_____ Wake up unrefreshed in the morning

_____ Have a problem with daytime sleepiness

_____ Have a teacher or anyone who has commented about sleepiness during the day

_____ Have difficulty waking up in the morning

_____ Wake up with headaches

_____ Have any history of growth problems

_____ Have an overweight issue: Weight is _____ Height is _____

_____ Complain of restless or achy legs

_____ Have arms and/or legs that twitch during sleep

_____ Have nightmares (more than one per week)

Signature of person completing questionnaire:_____

Name of person completing questionnaire if not patient:_____