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
Fax: (920)867-3108
Email: info@drtwohig.com

Office 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 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 payment. 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 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.

Dr. William J Twohig DDS
PO Box 579
Weyauwega, WI 54983
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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:** _____

William J. Twohig, DDS

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 PRIVAY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUT LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. The law also requires us 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 we describe 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 applicable law permits the changes. 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 DISCLAIMERS OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal privacy rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy riles and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 make revoke it in writing at any time. Your revocation will not affect any use or disclosure 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 this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist a person involved in your care, of your location and general condition.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employees regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, report crimes in emergencies, and for purposes of identifying or locating a suspect or other person
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to aver a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 have a request in writing to obtain access to your health information. You may request access by sending us a letter at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may-but are not required to-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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more

than once in a 12-mont 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 more information about fees.

Restrictions: You have the right to request that we place additional restrictions on our use a 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). 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. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed 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 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.

Provider Contact Office: ___Beth Swanson_____
Telephone: __(920) 867-3101_____ Fax: ___(920) 867-3108_____
E-Mail: __twohigdental@centurytel.net_____
Address: __P.O. Box 579, 417 E. Ann St., Weyauwega, WI 54983_____