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:

William J Twohig DDS, LLC

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:_____

Dental History William J Twohig DDS, LLC

Patients Name: _____

Last First Initial Date of Birth

1. Purpose of initial visit: _____
2. Are you aware of the problem? _____
3. How long since your last visit? _____
4. What was done at that time? _____
5. Previous dentist name _____
   a. Location, Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW LEAVE BLANK.

7. Have you made regular visits? ---------- YES NO
8. Were dental x-rays taken? ---------- YES NO
9. Have you lost any teeth or have any been removed? ---------- YES NO
   a. Why? _____
10. Have they been replaced? ---------- YES NO
11. How have they been replaced? ---------- YES NO
    a. Fixed Bridge _____ Age _____
    b. Removable Bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
    e. Not Sure/None _____
12. Are you unhappy with the replacement? ---------- YES NO
    a. If yes, explain: _____
13. Would you like to know about permanent replacements? ---------- YES NO
14. Have you ever had any problems or complications with previous dental treatment? ---------- YES NO
    a. If yes, explain: _____
15. Do you clench or grind your teeth? ---------- YES NO
16. Does your jaw click or pop? ---------- YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear? ---------- YES NO
18. Do you have frequent headaches, neckaches, or shoulder aches? ---------- YES NO
19. Does food get caught in your teeth? ---------- YES NO
20. Are any of your teeth sensitivity to: HOT COLD SWEETS PRESSURE
21. Do your gums bleed or hurt? ---------- YES NO
    a. When? _____
22. Do you experience dry mouth? ---------- YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ---------- YES NO
    a. How often _____
25. Are any of your teeth loose, tipped, shifted, or chipped? ---------- YES NO
26. Are you unhappy with the appearance of your teeth? ---------- YES NO
27. How do you feel about your teeth in general? ---------- YES NO
28. Do you feel your breath is offensive at times? ---------- YES NO
29. Have you had any gum treatment or surgery? ---------- YES NO
    a. What _____
    b. Where _____
    c. When _____
30. Have you had orthodontic work? ---------- YES NO
31. Have you had any unpleasant dental experiences or is there anything about dentistry that your strongly dislike? ---------- YES NO
32. Do you have any questions or concerns? ---------- YES NO

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

Med. Alert

Dr. William J Twohig DDS, LLC
417 E Ann Street
PO Box 579
Weyauwega, WI 54983
Phone: 920-867-3101

Office and Financial Policies

Appointments

Our automated reminder system 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. 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.

Continuous 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.

Insurance & Financials

Our dental practice works with most dental insurance plans; however, we are an out of network (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, 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.

We accept cash, check, all major credit cards, Care Credit. If you are unfamiliar with Care Credit 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: _____ Date_____
(Please Print)

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

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:** _____

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Patient Authorization to Transfer/ Forward Records

I, _____, hereby request and authorize
(*Patient or Guardian name, **please print***)

_____
(Current *practice or dentist name*)

to turn over my dental records to **Dr. William J. Twohig DDS**.

By authorizing the transfer, I understand that I am not impairing

_____
(*Name of current dentist transferring records*)

right of access to my records, when necessary, during the time period in which I was under his/ her care.

Sign: _____
(*Patient or Guardian signature*)

Date: _____

Email is our preferred method of transfer. Please send records to: info@drtwohig.com
-OR-
Dr. William J. Twohig
PO Box 579
Weyauwega, WI 54983

NOTICE OF PRIVACY PRACTICES

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

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [**EDIT:** [we will] [we usually will not]] ask you for special written permission.

[**EDIT:**[We will ask for special written permission in the following situations: _____.]]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get

an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.