DR. DAVID HUGGETT | DR. CHUCK KEANE

Patient Information

OAK FOREST DENTAL

Personal Information

Patient's Name _____ Today's Date _____

Nickname/Preferred Name *(if any)* _____ Birth date _____ S.S. # _____-____-_____

Status *(please circle)* Child / Adult Single Married Divorced Widowed Parent's/Spouse's Name _____

Billing Address _____ City/Sate _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail Address *(for appointment reminders)* _____

Best time to reach you is? _____ Preferred method of contact? _____

Employment

Employer _____ Job Title _____

Work Address _____ City/Sate _____ Zip _____

Work Phone _____ May we call you at work? _____

If so, what time is best to reach you? _____

Spouse's Employer _____ Work Phone _____

If student, name of school _____

Whom may we thank for referring you?

Name _____ Relationship _____

Did you hear about us in any other way? _____

_____

Dental Insurance

Insured's Name _____ Relationship to Patient _____

Insured's Birth Date _____ S.S. # _____-____-_____ Employer _____

Insurance Company _____ Yearly Benefit $ _____ Deductible $ _____

Secondary Insurance *(if applicable)*

Insured's Name _____ Relationship to Patient _____

Insured's Birth Date _____ S.S. # _____-____-_____ Employer _____

Insurance Company _____ Claims Address _____

By signing this, I authorize Oak Forest Dental to release any patient record information needed to process benefit claims and to submit claims for services I or my dependents will receive. I also assign directly to Oak Forest Dental all insurance benefits, if any, for services rendered and I agree to be responsible for all charges not paid by my insurance.

x Patient/Parent Signature _____ Date _____

I have received and read the "Oak Forest Dental Notice of Privacy Practices" and consent to the use and disclosure of my health information to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice. I understand that I have a right to revoke consent at any time by giving a written notice.

x Patient/Parent Signature _____ Date _____

x Parent's Name *(please print)* _____

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Patient Health History

OAK FOREST DENTAL

Knowing your health history helps us plan for better dental health. Please let us know if you have any questions about this form or need any assistance.

Name _____ Age _____ Birth Date _____

Name of Physician and Clinic_____ Physician's Phone # _____

Emergency Contact Name_____ Contact's Phone # _____

Please circle your response to the following questions

YES NO Have there been any changes to your health in the last year?

YES NO Are you currently under the care of a physician? If so, please explain: _____

_____

YES NO Have you ever taken antibiotics before dental treatment?

YES NO Have you ever had unfavorable reactions to dental materials?

YES NO Are you taking a blood thinning medication?

YES NO Do you take cortisone or steroid medications?

YES NO Are you taking medicines for osteoporosis (i.e. Fosamax, Actonel or Boniva)?

Are you allergic to any of the following? *(please circle)*

Penicillin Y / N Codeine Y / N Aspirin Y / N Latex Y / N

Acrylic Y / N Metals or Jewelry Y / N Local Anesthetics Y / N Sulfites/Wine Y / N

Other Allergies: *(please list)* _____

_____

*Please mark **(✓)** the following health conditions as they apply to you:*

_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Rheumatic Fever
_____ Heart Attack
_____ Angina
_____ Heart Disease/Arrhythmia
_____ High Blood Pressure
_____ Stroke
_____ Pacemaker
_____ Artificial Joints
_____ Back or Neck Problems
_____ Osteoporosis
_____ Arthritis
_____ Asthma
_____ Tuberculosis

_____ Respiratory Problems/Emphysema
_____ Anti-Coagulation therapy
_____ Blood Disorder
_____ Anemia
_____ Excessive Bleeding/Bruising
_____ Liver Disease
_____ Diabetes
_____ Kidney Disease
_____ Glaucoma
_____ Ulcers
_____ Thyroid disease
_____ Drug Dependency
_____ Psychiatric care
_____ Headaches

_____ MS
_____ Epilepsy/Seizures
_____ HIV Positive
_____ Hepatitis – Type ( )
_____ Cancer
_____ Chemotherapy
_____ Bisphosphonate Therapy
_____ Radiation
_____ Cold Sores
_____ Canker Sores
_____ Dry Mouth
_____ TMJ Pain
_____ Do you smoke?
_____ Do you chew tobacco?

Women: Are you Pregnant? _____ Due date:_____ Are you nursing?_____

Have you ever had any serious illness or operation not listed above? Y / N If yes, please explain: _____

_____

– over –

Ph: 608+781+4992 | Fax: 608+781+4976 | 1062 Oak Forest Drive + Onalaska, WI 54650 | www.oakforestdental.com

Medications: Please list below any medications you are taking, either prescription or non prescription.

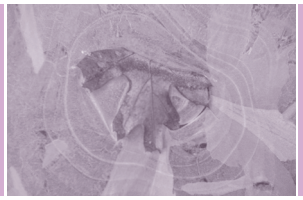
Drug	Reason for taking	*For office use only*

x Signature _____ Date_____

* 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.

x Signature *(parent or guardian)* _____ Date_____

For office use only



OAK FOREST DENTAL

DR. DAVID HUGGETT | DR. CHUCK KEANE

Financial Policy

Office Financial Policy & Important Information Regarding Your Dental Insurance

At Oak Forest Dental, we are committed to providing you with the best care possible for your personal situation. If you are fortunate enough to have dental insurance we will help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

We accept cash, personal checks, MasterCard, Visa, and Discover. In addition, we offer an excellent third party no-interest payment plan for balances over $1000. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. Returned checks and outstanding balances older than 90 days may be subject to finance charges at the monthly rate of 1.5%.

If you have dental insurance, you must bring proof of insurance and we will be more than happy to submit your insurance claims for you. However, you must realize:

1. *Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.*
2. *We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the date the services are rendered.*
3. *Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*
4. *Remember, please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.*

You may direct the insurance company to pay their share of the cost directly to our office (Assignment of Benefits). Often, we do not receive these payments until two to four months after being submitted for payment; therefore, we do ask that you pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment, we will reconcile your account and bill or refund any difference.

We must emphasize that as dental care providers, our relationship is with you, the patient, not your insurance company. While filing the insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such situations do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. We are here to serve you.

I have read the policies described in this form. I agree to abide by the terms outlined. I understand and accept my financial responsibilities.

x _____ _____

Signature of Responsible Party *Date*

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Notice of Privacy Practices

OAK FOREST DENTAL

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 01/01/10, 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 any 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 this 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 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 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

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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 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 $0 for each page, $0 per hour for staff time to 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 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 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 location, and provide satisfactory explanation 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 Web site or by electronic mail (e-mail), 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 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.

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.

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 management of our medical records and certain auditing and review activities by staff 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 or other crimes. We may report child abuse and the abuse or neglect of a vulnerable adult as allowed by Wisconsin law.

PATIENTS RIGHTS

Restriction: While we are allowed to determine whether 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: Wendy Horn
Telephone: 608-781-4992 • Fax: 608-781-4976
Email: info@oakforestdental.com
Address: Oak Forest Dental, 1062 Oak Forest Drive, Onalaska, WI, 54650