welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name _____
   Address _____ Tel: ( )
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in comments section ~~or on the back of this form.~~)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) .. YES NO
6. Are you allergic to any medications or substances? (please list) ..... YES NO
7. Do you have any other allergies or hives? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? (please circle) ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
21. Do you have any artificial joints/prosthesis? ..... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
23. Have you ever bled excessively after being cut or injured? ..... YES NO
24. Do you have any stomach problems? ..... YES NO
25. Do you have any kidney problems? ..... YES NO
26. Do you have any liver problems? ..... YES NO
27. Are you diabetic? ..... YES NO
28. Do you have fainting or dizzy spells? ..... YES NO
29. Do you have asthma? ..... YES NO
30. Do you have epilepsy or seizure disorders? ..... YES NO
31. Do you or have you had venereal or any sexually transmitted disease? ..... YES NO
32. Have you tested HIV positive? ..... YES NO
33. Do you have AIDS? ..... YES NO
34. Have you had or do you test positive for hepatitis? ..... YES NO
35. Do you or have you had T.B.? ..... YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? ..... YES NO
38. Do you habitually use controlled substances? ..... YES NO
39. Have you had psychiatric treatment? ..... YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there anything else we should know about your health that we have not covered in this form? _____
43. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

MEDICAL HISTORY

Patient Evaluation Form

1. How did you hear about our practice?
   - ❑ Referred by a friend
   - ❑ Directory of dentists provided by my insurance company
   - ❑ I saw one of your advertisements
   - ❑ Walk by or drove by the practice
2. Date of your last hygiene visit: _____
3. On a scale of 1 to 5 *(1 being bad, 5 being good)* please rate how you feel your overall dental health is.

   1 2 3 4 5
4. On a scale of 1 to 5 *(1 being bad, 5 being faithful)* Over the last ten years rate how faithfully you have had your teeth cleaned?

   1 2 3 4 5
5. On a scale of 1 to 5 *(1 being not sensitive, 5 being very sensitive)* what is you're level of sensitivity to dental procedures?

   1 2 3 4 5
6. On a scale of 1 to 5 *(1 being not sensitive, 5 being very sensitive)* what is your sensitivity to cleaning visits?

   1 2 3 4 5
7. Rate how you feel about your smile and the look of your teeth. *(1 being unhappy, 5 being very happy.)*

   1 2 3 4 5
8. Are you interested in regular hygiene cleanings?

   ❑ Yes ❑ No
9. What is the main reason for your visit today?
   - ❑ Tooth pain
   - ❑ I need to check up
   - ❑ Cleaning
   - ❑ Orthodontics (braces)
   - ❑ Whitening
   - ❑ Cosmetic dentistry
   - ❑ Sedation dentistry
   - ❑ Other _____
10. I would like to learn more about?
    - ❑ Orthodontics
    - ❑ Whitening
    - ❑ Cosmetic dentistry
    - ❑ Sedation dentistry
    - ❑ Implants
    - ❑ Bridges
    - ❑ Veneers
    - ❑ Dentures
    - ❑ Other _____
11. Referred to our office by:

    _____

Thomas H Gietman, DDS

100 Hwy W | MOUNT CALVARY WI, 53057 | (920) 753-2771

Written Financial Policy

Thank you for choosing Thomas H Gietman, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care.

- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

Thomas H Gietman, DDS requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

There is a $25 fee for returned checks.

We appreciate a 24 hour notice if unable to keep an appointment.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

As required by law, I have received from Thomas H. Gietman, D.D.S., or one of his agents, the Notice of Privacy Practices for Thomas H. Gietman, D.D.S. required elements for Notice of Privacy Practices (sec.164.520), and the Wisconsin Addendum to Notice of Privacy Practices. These notices describe how healthcare information about my family and me may be used and disclosed and how I can get access to this information.

NAME_____

DATE_____

Thomas H. Gietman, D.D.S.
Mt. Calvary Medical Center
Mt. Calvary, WI 53057
PHONE: 753-2771

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: Individual giving consent.

NAME: _____

PATIENT NAME: (If different than above) _____

ADDRESS: _____

TELEPHONE: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION B: The uses and disclosures being authorized.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care. By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

_____ _____

_____ _____

_____ _____

We may use professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information. By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: Thomas H. Gietman, D.D.S.
Telephone: 920-753-2771
Address: 100 S. Hwy. W, Mt. Calvary, WI 53057

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature:_____ Date:_____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's/Parent Name:_____

Relationship to Individual:_____

THOMAS H. GIETMAN, D.D.S.
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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2015 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV- related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

TREATMENT We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

PAYMENT We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

HEALTHCARE OPERATIONS We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat the patient representative the same way we would treat you with respect to your health information.

DISASTER RELIEF We may use or disclose your health information to assist in disaster relief efforts.

REQUIRED BY LAW We may use or disclose your health information when we are required to do so by law.

PUBLIC HEALTH ACTIVITIES We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

NATIONAL SECURITY We may disclose to military authorities the health information of Armed Forces to personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

SECRETARY OF HHS We will disclose your health information to the Secretary of the U.S. Department of Health and Human services when required to investigate or determine compliance with HIPPA.

WORKER'S COMPENSATION We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

LAW ENFORCEMENT We may disclose your PHI for law enforcement purposes as permitted by HIPPA as required by law, or in response to a subpoena or court order.

HEALTH OVERSIGHT ACTIVITIES We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain in an order protecting the information requested.

RESEARCH We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

CORONERS, MEDICAL EXIMINERS, AND FUNERAL DIRECTORS We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We my also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

FUNDRAISING We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain our written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

ACCESS You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.
If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

DISCLOSURE ACCOUNTING With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in 12 month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

RIGHT TO REQUEST A RESTRICTION You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (l) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on our behalf (other than the health plan), has paid our practice in full.

ALTERNATIVE COMMUNICATION You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

RIGHT TO NOTIFICATION OF A BREACH You will receive notifications of breaches of your unsecured protected health information as required by law.

ELECTRONIC NOTICE You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if 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 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.

OUR PRIVACY OFFICIAL: Office Manager

TELEPHONE: (920)753-2771

ADDRESS: 100 Evergreen Rd., Mt. Calvary, WI 53057