

# Stoeckl Dentistry - Health History

W359 N5002 Brown St. Ste 210, Oconomowoc, WI 53066 (262)567-5600

PLEASE COMPLETE BOTH SIDES OF THIS DENTAL/MEDICAL FORM. ALL INFORMATION IS COMPLETELY CONFIDENTIAL.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Have you been hospitalized in the last 5 years? No / Yes Reason \_\_\_\_\_

Are you receiving medical care? If Yes, why? \_\_\_\_\_ Last health exam: \_\_\_\_\_

Please list names/phone numbers of doctors who are currently providing care for you..

1. \_\_\_\_\_ 2. \_\_\_\_\_

Please list any medications (including Herbal) you are currently taking: (1) \_\_\_\_\_

(2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_

## Are you taking or have you taken the following medications:

(1) Oral bisphosphonates (for tx. of osteoporosis)... \*Tiludronate (Skelid) Y/N \_\_\_\_\_

\*Alendronate (Fosamax) Y/N \_\_\_\_\_ \*Etidronate (Didronel) Y/N \_\_\_\_\_

\*Ibandronate (Boniva) Y/N \_\_\_\_\_ \*Risedronate (Actonel) Y/N \_\_\_\_\_

(2) Intravenous therapy for bone metastases of cancer and hypercalcemia of malignancy....

\*Pamidronate (Aredia) Y/N \_\_\_\_\_ \*Zoledronic acid (Zometa) Y/N \_\_\_\_\_

Woman: Are You Pregnant? No / Yes How far along? \_\_\_\_\_ Are You a Nursing Mother? No / Yes

Do You Need to Pre-Medicate / Take antibiotics one hour before your dental appts.?) No / Yes

Please Circle or List Any Allergies / Sensitivities You Have: Metal allergy: No / Yes

Latex Allergy: No / Yes Penicillin or Antibiotics: No / Yes \_\_\_\_\_

Tetracycline/Minocycline: No/Yes Milk Protein/and or hydrobenzoates: No/Yes

Other: \_\_\_\_\_

## Do You Have or Have You Been Treated For Any of the Following...

Rheumatic Fever No / Yes Steroid Treatment No / Yes

Heart Murmur No / Yes Epilepsy No / Yes

Mitral Valve Prolapse No / Yes Glaucoma No / Yes

Valve Replacement No / Yes Arthritis No / Yes

Heart (Surgery, Disease, Attack) No / Yes Joint Disease No / Yes

Abnormal Heart Condition No / Yes **Joint Replacement** **No / Yes**

Abnormal Blood Pressure: High / Low / normal Sinus Troubles No / Yes

Arteriosclerosis No / Yes Ulcers No / Yes

Angina Pectoris No / Yes Cancer: Past / Current No / Yes

Heart Pacemaker No / Yes Radiation Treatment No / Yes

Stroke No / Yes HIV Infection/AIDS No / Yes

Diabetes: Type I / Type II No / Yes Venereal Disease No / Yes

Emphysema /Respiratory Illnesses No / Yes Herpes I / II No / Yes

Asthma No / Yes Psychiatric Treatment No / Yes

Tuberculosis No / Yes Depression / Anxiety Disorder No / Yes

Thyroid Condition Hyper / Hypo / normal Eating disorders No / Yes

Kidney Disease No / Yes Drug/Alcohol Addiction No / Yes

Liver Disease No / Yes **Organ Transplant** **No / Yes**

Hepatitis, A / B / C No / Yes Any Other Health Conditions Not Mentioned: \_\_\_\_\_

Bleeding / Bruising Disorder No / Yes \_\_\_\_\_

Anemia No / Yes \_\_\_\_\_

Blood Disorder / Disease No / Yes \_\_\_\_\_

**Are You a Smoker?** No / Yes    How Much Do You Smoke Per Day? \_\_\_\_\_  
**Do You Chew Tobacco?** No/Yes    How Often? \_\_\_\_\_

**Please Circle Any of the Following That Apply to Your Dental Health...**

- Clicking or Popping of the Jaw Joint
- Pain In or Around Your Ears
- Pain with Neck / Pain in Facial Muscles
- Migraines
- Difficulty Opening or Closing Your Mouth
- Have You Ever Been Diagnosed with TMJ / TMD
- Trauma to Jaw
- Clench / Grind Teeth    AM / PM
- Difficulty Chewing
- Loose Teeth
- Swelling
- Bleeding Gums
- Bad Taste in Mouth
- Bad Breath (Halitosis)
- Sores / Lumps / Growths in Mouth
- Food Gets Stuck Between Your Teeth
- Sensitive teeth? No / Yes    Hot / Cold

**Please Answer the Following Dental Questions...**

Have you ever had instructions in oral hygiene?    No / Yes

Are you satisfied with your teeth's appearance?    No / Yes \_\_\_\_\_

Are you having pain or discomfort at this time? If yes, explain \_\_\_\_\_  
\_\_\_\_\_

**Please take a minute and let us know if there is anything else that you feel we need to know to help make this visit more comfortable for you.**

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**I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.**

X \_\_\_\_\_  
**Signature of patient or guardian**

\_\_\_\_\_  
**Date**

**Stoeckl Dentistry - New Guest Registration**  
**W359 N5002 Brown St. Ste 210, Oconomowoc, WI 53066 (262)567-5600**

Last Name: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: M/F Birth date \_\_\_\_\_ Single/ Married/ Widow/Separated /Divorced

Social Security # \_\_\_\_\_ If College Student, FT/PT , where \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone # (only write down if we can contact you at work): \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**How would you like your appointments confirmed? (PLEASE CIRCLE ALL THAT APPLY):**  
TEXT MESSAGE-----EMAIL-----HOME PHONE

Can we leave a personal dental treatment message on your home phone or cell phone? Yes / No

Can we leave a personal dental treatment message with your spouse? Yes / No

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

What is your previous Dentist's name and address? \_\_\_\_\_

**If you or your child is receiving orthodontic care, please provide us with the name and phone number of your Orthodontist:**

Orthodontist: \_\_\_\_\_ Phone number: \_\_\_\_\_

**If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below.**

Name of responsible party or parties \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M/F Birth date \_\_\_\_\_ Single/ Married/ Widow /Separated/ Divorced

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Will anyone else besides yourself or your child's other parent be bringing the child to their dental appts.?

NO / YES If yes, who will be bringing your child (i.e.: acting as guardian?) \_\_\_\_\_

## **Stoeckl Dentistry - Treatment Consent and Office Policy:**

- I hereby authorize Stoeckl Dentistry to perform consented dental procedures. Stoeckl Dentistry understands and believes in INFORMED PATIENT CONSENT. This means that Stoeckl Dentistry will inform me of all dental treatment before initiating any dental treatment, unless it is an absolute medical emergency. Stoeckl Dentistry will also offer me alternative treatment options, advising me as to the advantages and disadvantages of the treatment and the consequences if the treatment is withheld. If during the course of executing the designated treatment unforeseen conditions arise, Stoeckl Dentistry will inform me of the change in treatment.
- If anesthetic is desired...

I consent to the administration of local anesthesia and understand that there is a slight element of risk inherent in the administration of local anesthetic. This risk includes adverse drug response (allergic reactions), cardiac arrest, thrombophlebitis (irritation and swelling of a vein), pain, discoloration and injury to blood vessels, and possible injury to nerves (temporary to permanent numbness).
- I realize that in spite of possible complications and risks, my contemplated treatment is desired by me. I acknowledge that no guarantees have been made to me concerning the result of the procedures, as we are dealing with the human body. However, Stoeckl Dentistry stands behind their work and will do their best to give me the best possible dental treatment.
- I authorize Stoeckl Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Stoeckl Dentistry, otherwise payable to me.
- We need 48 hours notice prior to canceling or rescheduling an appointment. We understand emergencies do happen. We reserve specific time with our doctors/hygienists for your scheduled dental treatment.
- **We only place white (resin) fillings. We don't place silver-mercury (amalgam) fillings.**
- If I have any questions regarding this consent, I will ask before signing.
- I certify that I have read and understand the above information to the best of my knowledge.

X \_\_\_\_\_  
(SIGNATURE OF PATIENT OR GUARDIAN)

\_\_\_\_\_  
(DATE)

# Financial Policy

We believe in providing clear and responsible communication about financial issues. **You are responsible for all fees, including copays and deductibles, for services provided the same day of service.**

At Stoeckl Dentistry, we are committed to providing the best treatment for our guests. Our fees are based on time, materials, and continuing education for doctors and team members. You are responsible for payment regardless of your insurance company's determination of usual and customary rates. We will be happy to file claims with your insurance.

As a courtesy, we will work with you and your insurance company by getting a full run down of your dental benefits. However, it is your responsibility to know your coverage and benefits at any given time. We will provide you with the best estimate we can based on the information we receive from your insurance company for any copays or deductibles that are required. Please remember this is just an estimate. Insurance companies do not guarantee anything over the phone or in writing, and therefore any additional costs not covered by your insurance company after claims are processed are your responsibility. Please keep in mind that your insurance company has a contract with you and your employer, and not with Stoeckl Dentistry.

We accept cash, check, Visa, Mastercard, Discover, or Care Credit.

X \_\_\_\_\_  
(Signature of Patient or Guardian)

\_\_\_\_\_  
(Date)

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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**PATIENT GIVING CONSENT:** Name \_\_\_\_\_

Address: see New Patient Registration Form      Patient Number: see New Patient Registration Form

**Persons Involved in Care:**

List individuals who you would like involved in your dental care. By writing their names on this form, you consent to the release of your dental information to them. (For example, if you want us to be able to discuss dental information with your husband/wife, you must list their names below. This includes discussing fillings, crowns, insurance payments with them.) In addition, the account holder (not necessarily the insurance holder) may receive basic dental treatment information on mailed billing statements (example... John had cleaning on 1/1/07, Mary had filling on 1/1/07).

\_\_\_\_\_  
\_\_\_\_\_

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. If you decide not to sign this consent, we may decline to treat you.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, 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 Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Christopher Stoeckl. Telephone: 262-567-5600. Fax: 262-567-5566. Address: W359 N5002 Brown Street, Oconomowoc, WI

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

**CONSENT**

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative / guardian on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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{Stoeckl Dentistry}

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Signature or Guardian Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
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**FOR YOUR INFORMATION ONLY. NO SIGNATURES NEEDED.**

# **NOTICE OF PRIVACY PRACTICES**

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**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.**

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## **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 (MM/DD/YR), 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.

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## **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:** Your permissions authorizes the use of your health information for treatment, payment or healthcare operations. You may give us written authorization to disclose your health information 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, \$\_\_\_\_ per hour for staff time to locate and 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**

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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.

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