Darling Dental

Patient Information:

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email address: _____ How would you like to be contacted? _____

Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's Employer: _____

Spouse or Parent/Guardian's Name: _____

Employer:_____ Work Phone: _____

Person to contact in case of emergency: _____

Relationship: _____Phone #_____

Dental Insurance: Yes or No

Insurance Company:_____ Insured's Name: _____

Insured's SSN or ID# : _____ Insured's DOB: _____

Insurance Company's phone number: _____

Responsible Party:

Name of person responsible for this account: _____

Relationship to patient: _____

Address:_____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Birthdate: _____

Employer: _____

Is this person currently a patient in our office? Yes No

Payment is expected at each appointment. For your convenience, we offer the follow methods of payment.

Cash, all major credit cards and Care Credit

How did you hear about our office? Darling Dental website, Delta Dental website,

friend (we'd like to thank him/her), other: _____

Patient Medical History

Patient Name: _____

Physician: _____ Office Phone: _____

Date of last exam: _____

Please Circle Yes or No

1. Are you under medical treatment now? **Y / N**

2. Have you ever been hospitalized for any surgical operation, serious illness, **or have you had any joint replacements**? **Y / N**

If yes, please explain and give date of operation_____

3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? **Y / N**

_____

4. Have you ever taken Fen-Phen/Redux? **Y / N**

5. **Have you ever taken/had injections of bisphosphonates (Zometa, Reclast, Aredia, Xgeva)? Y / N**

6. Do you currently or have you ever used tobacco? **Y / N**

7. Do you use controlled substances? **Y / N**

8. **Are you pregnant or breastfeeding**? **Y / N**

9. **Are you allergic to or have you had any reactions to the following**?

Local Anesthetics (e.g. Novocain)	Penicillin or any other Antibiotics
Sulfa Drugs	Barbiturates
Sedatives	Iodine
Aspirin	Any metals (e.g. nickel, mercury, etc.)
Latex rubber	Other:_____

10. Have you ever had cancer? **Y / N** If yes- what kind, when and are you under treatment now?

_____

11. Please circle if you have or have had any of the following:

High or Low Blood Pressure	Leukemia	Angina	Easily Winded
Heart Attack	Diabetes	Stroke	Frequently Tired
Rheumatic Fever	Kidney Disease	Hay Fever	Tuberculosis
Swollen Ankles	AIDS/HIV	Anemia	Radiation/Chemo Therapy
Fainting/Seizures	Thyroid Problem	Emphysema	Glaucoma
Asthma	Heart Disease	Arthritis	Recent Weight Loss
STD's/HPV	Cardiac Pacemaker	Heart Trouble	Liver Disease
Epilepsy/Convulsions	Heart Murmur	Respiratory Problems	Chest Pains
Mitral Valve Prolapse	Cold Sores	Stomach Troubles/Ulcers	Heart Valve replacements

Other, please explain:_____

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

Please Circle Yes or No

1. Do your gums bleed while brushing or flossing? **Y / N**
2. Are your teeth sensitive to hot or cold liquids/foods? **Y / N**
3. Are your teeth sensitive to sweet or sour liquids/foods? **Y / N**
4. Do you feel pain to any of your teeth? **Y / N**
5. Do you have any sores or lumps in or near your mouth? **Y / N**
6. Have you had any head, neck or jaw injuries? **Y / N**
7. Have you ever experienced any of the following problems in your jaw?

   Clicking Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing
8. Do you have frequent headaches? **Y / N**
9. Do you clench or grind your teeth? **Y / N**
10. Do you bite your lips or cheeks frequently? **Y / N**
11. Have you ever had any difficult dental extractions in the past? **Y / N**
12. Have you ever had any prolonged bleeding after dental extractions? **Y / N**
13. Have you had any orthodontic treatment? **Y / N**
14. Do you wear dentures or partials? If yes, date of placement _____ **Y / N**
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? **Y / N**
16. Do you like your smile? **Y / N**
17. Do you have any chief concerns regarding your smile/oral health? Please explain:

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (Or parent/guardian if minor)

X_____

Print Name (Or parent/guardian if minor)

X_____

Signature of treating dentist

TMJ HEALTH QUESTIONNAIRE
Please answer all questions to the best of your ability.

CHIEF CONCERN or N/A_____

DATE OF ONSET or N/A_____

JAW JOINT SYMPTOMS

Do you have pain in your jaws? Right, left or both	Y	N	Does your jaw feel tired after a big meal?	Y	N
Are you capable of chewing gum?	Y	N	Are there any foods you avoid eating?	Y	N
Are you capable of chewing a bagel?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you hear noises in your jaw joint	Y	N	Do you ever get dizzy?	Y	N
Has your jaw ever locked open or closed?	Y	N	Does your jaw ache when you open wide?	Y	N
Can you make your jaw pop or crack?	Y	N	Do you ever feel faint?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N	Do you ever feel nauseated?	Y	N

PAIN SYMPTOMS

Do you get headaches?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you get migraine headaches?	Y	N	Do you get headaches in the front or back of your head?	Y	N
Do you frequently have neck aches or stiff neck muscles	Y	N	Do you clench your teeth during the day?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N	Do you think you clench your teeth at night?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you think you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken?	Y	N	When are your pain symptoms the worst?		
Are your teeth sore when you awaken?	Y	N			
Have your wisdom teeth been extracted?	Y	N	Does anything make you feel better?		

What medications, if any, are you taking? _____

How often do you take medication for relief of pain? _____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Any whiplash neck injuries	Y	N	Details: _____		

EAR AND EYE SYMPTOMS

Do you have pain in either ear?	Y	N	Do you wear glasses or contacts?	Y	N
Do you suffer from any loss of hearing?	Y	N	Are there times when your eyesight blurs?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N	Do you get pain in, around or behind either eye?	Y	N
Do you hear ringing, buzzing, or hissing sounds in either ear?	Y	N			

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N	Have you been diagnosed with Sleep Apnea?	Y	N
Do you snore at night?	Y	N	Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N

Darling Dental

Nathan S. Darling, D.D.S.

7161 N. Port Washington Rd

Glendale, WI 53217

414-247-1470

FINANCIAL POLICY & INSURANCE INFORMATION

Payment is due at the time of service. If you have dental insurance, your co-pay and/or deductible is due at the time of service. Patients without dental insurance are expected to make full payment at the time of service. We do not offer payment plans. We accept cash, all major credit cards and Care Credit.

A Word About Dental Insurance:

As a courtesy, Darling Dental is happy to submit insurance claims for you. However, we remind you that **your policy is an agreement between you and your insurance company, not between your insurance company and our office.** Our fees may be above or below the "usual and customary" fee provided to you by your insurance company. This may have an effect on the amount you will be responsible for. We can make no guarantee of any estimated coverage, but we'll do our best to see that you receive your maximum benefits. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

Pretreatment Estimates:

If you would like a treatment plan estimate or pre-treatment estimate sent to your insurance, please ask.

Please turn over >>>>>>>

Broken Appointments:

We respect your time and always make every effort to remain on schedule. For this reason, we schedule only one person at a time. This allows the doctor to provide personalized care. We have set this time aside exclusively for you. If you are unable to keep an appointment, kindly give us **48-hour** notice. This courtesy on your part makes it possible to give your canceled appointment time to another patient in need of care. A fee of $50.00 or more will apply to a broken appointment or a canceled appointment without a 48-hour notice.

Overdue Accounts:

Since our office is not equipped to handle overdue accounts, any account that reaches 90 days, will be sent to a collection agency. You will be responsible for any additional charges involved in the collection of your account, which could be 33.33%-50% of your total balance. An account will not be sent if prior financial arrangements have been made and you are complying with that agreement.

_____

If you have any questions concerning our office financial policy, please discuss them with us before treatment is performed.

I have read and understand **Darling Dental's** financial policy and agree to the terms and conditions stated.

_____ _____

Patient/Guarantor Signature Date

OR

_____ _____

Parent/Guardian Signature Date

Darling Dental

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 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 take effect 12/01/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practice 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 or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of 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 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 revocations 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 of 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 reasonable 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 circumstances. We may disclose to correctional institutions 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).

PATIENT RIGHTS:

Access: You may 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 practicable 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 $20 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 purposed, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 24, 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 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 (email), 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 contact us using the 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 the U.S. Department of Health and Human Services.

Contact Officer: Dana Darling
Email: darlingdental@gmail.com
Telephone: 414-247-1470
Fax: 414-247-1490
Address: 7161 N Port Washington Rd, Glendale, WI 53217

Darling Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of Darling
(Print Full Name)

Dental's Notice of Privacy Practices.

Signature: _____ Date: _____

Office Use Only

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: _____