Kendra S. Schaefer, DMD

Eaglesoft 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
Are you taking any medications, pills, or drugs?	○ 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	

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

Do you use controlled substances?	○ Yes ○ No	If yes
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	○ 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:_____

prosthodonticsofmadison
kendra s. schaefer, dmd

Dental Services Financial Policy

Welcome to Prosthodontics of Madison. Our goal is to provide you with the highest quality care available. We are committed to helping you determine the most appropriate treatment for your dental needs. Should you have questions concerning your treatment, treatment sequence, or fees for our services, please ask for clarification before treatment is started.

OUR FINANCIAL POLICY:

- For regular hygiene visits, oral evaluations, consultations and emergency visits, full payment is due at the time of service, regardless of insurance. For patient accepted treatment plans with ongoing periodic visits, proportional payment is due at the time of service for each stage of treatment, regardless of insurance.
- We accept the following forms of payment: Cash, Personal Checks, Visa and MasterCard
- Payment plans for certain procedures are offered through *The Lending Club Patient Financing* with 0% interest up to 1 year or low interest payment options available up to 7 years.
- Dental Insurance Benefits – Insurance is a contract between the patient and/or employer and their insurance company. There is no contract or agreement for compensation between our office and any insurance company. Further, because we are not a dental insurance network provider, insurance companies may or may not pay us directly for services provided to our patients. Also, our patients are usually referred from another dentist, and sometimes are then sent by us to a specialist (such as an Oral Surgeon for extractions). As a result, Prosthodontics of Madison has no way of knowing how much coverage remains available on a patient's dental insurance plan. As a courtesy to our patients, we are happy to assist your reimbursement process by filing your insurance claim(s)* and providing any details that the insurance company may require. You may wish to assign benefits to this office as we process your insurance claims for you. *Prosthodontics of Madison is not responsible for denied coverage or slow reimbursements by the insurance company. Responsibility for payment belongs solely to the patient (or patient's Responsible Party if patient is a minor.)
- We will provide estimates for our cost of services. Predetermination of benefits with insurance benefit plans may be advisable if there is a question concerning coverage. Nevertheless, preauthorization is not a guarantee of payment from the benefit plan.
- Extended treatment plans (treatment requiring more than one visit) will be outlined so that appropriate payments can be made as each phase of treatment is begun. **Prior to the beginning of treatment, an initial payment for services equal to that of 50% will be collected based on the proposed treatment plan.**

*If we are assigned benefits, your insurance company may still reimburse you directly. It is important for you to take an active role, communicating with your insurance company and with this office regarding reimbursements outstanding or paid to you.

By signing below, I am stating that I understand and agree to the above stated policy. I hereby authorize Prosthodontics of Madison to disclose to insurance companies all information contained in their health care records for the purpose of securing payment of any benefits that may be payable by said insurance companies for services rendered to me by Prosthodontics of Madison. The foregoing consent to disclosure of my health care records shall remain in effect until such time as I deliver a written notice to Prosthodontics of Madison stating that I have revoked their consent to the disclosure of my health care records to my insurance companies.

Regardless of remaining insurance coverage(s), I understand that I am personally responsible for all payments on their account in full at the time services are rendered. I acknowledge that a $25 fee will be assessed to their account for checks written that are returned for NSF (non-sufficient funds.) Should it become necessary to refer my account to an agency or attorney for collection, I acknowledge that I will be responsible for costs associated with collection, including any attorney's fees and/or court costs.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

Responsible Party Printed Name: _____

Responsible party Signature: _____ Date: _____

KENDRA S. SCHAEFER, DMD, LLC
PROSTHODONTICS OF MADISON

HIPAA OMNIBUS RULE AND WISCONSIN CONSENT FOR HIPAA PRIVACY
ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PURPOSE: This form is to obtain an individual's permission under Wisconsin law for (a) our use of the individual's patient health care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's patient health care records to carry out treatment, payment activities, and health care operations. This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you. 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 uses and disclosures of your protected health information (PHI) and of other important matters about your protected health information.

In signing this HIPAA Patient Acknowledgement and Consent form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

How do you wish to be addressed when called from the reception area (please check one):

_____ by First Name only _____ by Proper Surname (Mr./Mrs./Ms. with Last Name) Other: _____

I authorize contact from this office to confirm my appointments, treatment and billing/payment information via:

_____ Cell Phone _____Home Phone _____ Work Phone

Please list any other parties who can have access to your health information, your patient records and protected health information (PHI):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OUR NOTICE OF PRIVACY PRACTICES ARE INCLUDED IN THIS CLIPBOARD, DISPLAYED AT THE DESK AND ARE AVAILABLE FOR REVIEW AND PRINT ON OUR WEBSITE: WWW.PROSTHODONTICSOFMADISON.COM.

OUR DISCLOSURE OF MEDICAL INFORMATION: By signing this form, you will consent to our disclosure of your patient health care records to carry out treatment, payment activities, and health care operations as set forth in our Notice of Privacy Practices. HIV and/or Hepatitis B test results, if any, may be disclosed to persons and/or under circumstances specified in Wisconsin Statutes 252.15 (5).

CONSENT: I, (print your name) _____ have been informed of this office's Notice of Privacy Practices. I understand that by signing this form, I am confirming my written permission for the disclosure of my protected health information (PHI).

Signature _____ Date _____

Parent/Guardian/Personal Representative:
Signature _____ Date _____

KENDRA S. SCHAEFER, DMD, LLC
PROSTHODONTICSOFMADISON
612 RIVER PLACE MONONA, WI 53716
TEL: (608) 222-6606 FAX: (608) 571-0038

PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____

Street Address _____ ☐ Phone _____ ☐ Cell _____

City _____ State _____ Zip Code _____

Patient's Social Security No. _____ Email Address _____

Patient's Employer _____ ☐ Business Phone _____

Employer's Address _____

Person Responsible for Account _____

Relationship to Patient: ☐ Spouse ☐ Parent Guardian ☐ Other: _____

Address of Responsible Party _____

City _____ State _____ Zip Code _____

Social Security No _____

Responsible Party's Employer _____

Employer's Address _____

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Employment Phone _____

Who Referred You to Our Office? _____ ☐ Dr. ☐ Friend ☐ Internet ☐ Website

Name of General Dentist _____

Name of Physician: _____ Location: _____

DENTAL INSURANCE INFORMATION

Name of Primary Dental Insurance Co. _____

Street Address _____

City _____ State _____ Zip Code _____

Name of Insured Person _____ Date of Birth _____

Member Number _____ Social Security Number: _____

Group Number _____

Name & Address of Employer _____

Name of Secondary Dental Insurance Co. _____

Street Address _____

City _____ State _____ Zip Code _____

Name of Insured Person _____ Date of Birth _____

Member Number _____ Social Security Number _____

Group Number _____

Name & Address of Employer _____

Prosthodontics of Madison
Kendra S. Schaefer , DMD, LLC
612 River Place
Monona, Wisconsin 53716

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Prosthodontics of Madison, Kendra S. Schaefer , DMD, LLC understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 04/05/2018, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 another 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

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, mailing, 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 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 at 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Kristi Hammill
Telephone: 6082226606
E-mail: kristi@madisonpom.com
Address: 612 River Place
Zip Code: 53716
State: Wisconsin
City: Monona