Welcome to Milwaukee Smiles

735 N Water Street Ste. 926~Milwaukee, WI 53202 • Phone: 414.272.8866 • Fax :414.272.8831 • www.mkesmiles.com

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us; we will be happy to help!

Patient Information (CONFIDENTIAL)

Date _____

NAME _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Zip _____

Email (optional) _____ Cell Phone _____ Soc. Sec. # _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State/Zip _____

Spouse or Parent/Guardian's Name _____ Work Phone _____

Spouse or Parent/Guardian's Employer _____ City _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency (living in same home) _____ Phone _____

Person to Contact in Case of Emergency (not living in same home) _____ Phone _____

Responsible Party (if under 18 years of age only-No third party billing)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email (optional) _____ Cell Phone _____

Driver's License # _____ Birthdate _____ SSN _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? Yes No Are there other family members? Yes No

Insurance Information

Legal Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Co. Address _____ City _____ State/Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ Yes ❑ No **IF YES, PLEASE COMPLETE THE FOLLOWING:**

Name of Insured _____ Relationship to patient _____

Birthdate _____ SSN _____ Work Phone _____

Name of Employer _____ Union or Local # _____ State/Zip _____

Address of Employer _____ City _____ Policy ID # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ City _____ State/Zip _____

I consent to: The diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment.
I give consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care):

Name: **Relationship to Patient:**

_____ _____

_____ _____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize my payment directly to the dentist or dental group of insurance beneffits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill or services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the payer. I attest to the accuracy of the information on this page. **(PATIENTS 18 YEARS OF AGE AND OLDER MUST SIGN THIS FORM. THE SIGNATURE OF A PARENT, GUARDIAN OR SPOUSE IS NOT ACCEPTABLE).**

PATIENT'S OR GUARDIAN'S SIGNATURE: _____ DATE: _____

HEALTH HISTORY

Patient's Name_____Date of Birth_____Age_____

Are you in good health now? ☐ Y ☐ N

Are you now under a care of a physician? ☐ Y ☐ N
Physician's Name_____Phone#_____Date of last visit?_____
If so, what is the condition that you are being treated for?_____

Have you ever been hospitalized or had a serious illness? ☐ Y ☐ N
If yes explain_____

Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal than previously? ☐ Y ☐ N

(WOMEN) Are you pregnant? If so, give due date_____ ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N
Do you smoke or use tobacco in any form? If yes, how much_____ ☐ Y ☐ N
Do you use alcoholic beverages (more than one drink per day)?_____ ☐ Y ☐ N

Have you ever had any of the following diseases or medical conditions: Please circle what does & does not apply

GENERAL		
Tire easily, weakness	☐ Y	☐ N
Marked weight change	☐ Y	☐ N
Night sweats	☐ Y	☐ N
Persistent Fever	☐ Y	☐ N
SKIN		
Eruptions (rash) hives	☐ Y	☐ N
Changes in skin color	☐ Y	☐ N
EYES		
Visual Change	☐ Y	☐ N
Glaucoma	☐ Y	☐ N
EARS		
Loss of hearing	☐ Y	☐ N
Ringing in ears	☐ Y	☐ N
NOSE		
Frequent nose bleeds	☐ Y	☐ N
Sinus problems	☐ Y	☐ N
THROAT		
Soreness/ hoarseness	☐ Y	☐ N
NERVOUS SYSTEM		
Stroke	☐ Y	☐ N
Chronic Headaches	☐ Y	☐ N
Convulsions / epilepsy	☐ Y	☐ N
Numbness / tingling	☐ Y	☐ N
Dizziness / fainting	☐ Y	☐ N
Psychiatric treatment	☐ Y	☐ N
RESPIRATORY		
Tuberculosis	☐ Y	☐ N
Emphysema	☐ Y	☐ N
Asthma / hay fever	☐ Y	☐ N
Persistent cough	☐ Y	☐ N
Sputum production (phlegm)	☐ Y	☐ N
Cough up bloody sputum	☐ Y	☐ N
Difficulty breathing while lying down	☐ Y	☐ N
ENDOCRINE		
Diabetes	☐ Y	☐ N
Family history of diabetes	☐ Y	☐ N
Thyroid condition	☐ Y	☐ N
Other_____		

HEART / BLOOD VESSELS		
Rheumatic fever	☐ Y	☐ N
Heart murmur	☐ Y	☐ N
Chest pain / discomfort	☐ Y	☐ N
Heart attack / trouble	☐ Y	☐ N
Shortness of breath	☐ Y	☐ N
Swelling of ankles	☐ Y	☐ N
High blood pressure	☐ Y	☐ N
Congenital heart disease	☐ Y	☐ N
Artificial heart valve	☐ Y	☐ N
Pacemaker	☐ Y	☐ N
Heart Surgery	☐ Y	☐ N
Other_____		
BONE / MUSCLES		
Arthritis / rheumatism	☐ Y	☐ N
Artificial joints	☐ Y	☐ N
DIGESTIVE SYSTEM		
Hepatitis	☐ Y	☐ N
Jaundice	☐ Y	☐ N
Ulcers	☐ Y	☐ N
Change in appetite	☐ Y	☐ N
Black, bloody or pale stools	☐ Y	☐ N
URINARY		
Kidney disease	☐ Y	☐ N
Increase in frequency of urination (night)	☐ Y	☐ N
Burning on urination	☐ Y	☐ N
Urethral discharge	☐ Y	☐ N
Bloody Urine	☐ Y	☐ N
Venereal disease	☐ Y	☐ N
BLOOD		
Bruise easily	☐ Y	☐ N
Anemia	☐ Y	☐ N
Blood transfusion	☐ Y	☐ N
OTHER		
Radiation Therapy	☐ Y	☐ N
Tumors or growths	☐ Y	☐ N
Cancer	☐ Y	☐ N
HIV	☐ Y	☐ N
AIDS / ARC	☐ Y	☐ N

PLEASE TURN OVER

Are you allergic or have you ever experienced any reaction to the following? Please check what does apply

☐ Local anesthetics (e.g. novacane ☐ Aspirin ☐ Codeine ☐ Barbiturates ☐ Sedatives / Sleeping pills

☐ Sulfa drugs ☐ Penicillin / other antibiotics ☐ Latex ☐ Other allergies_____

Are you taking any of the following? Please check what does apply:

☐ Antibiotics ☐ Sulfa drug ☐ Blood thinners ☐ Digitalis ☐ Blood pressure medication ☐ Aspirin

☐ Thyroid medicine ☐ Cortisone/Steroids ☐ Antihistamines ☐ Allergy drugs ☐ Cold remedies ☐ Tranquilizers

☐ Insulin ☐ Other diabetic drugs ☐ Recreational drugs ☐ Other heart medication ☐ Other medication

Please list any current medication that you are on:

_____

_____

Dental History

What is the primary reason for your visit to our practice today?

_____

Are you currently in pain? ☐ **Y** ☐ **N**

Do you require antibiotics before dental treatment? ☐ **Y** ☐ **N**

When was the last time you had a complete dental evaluation? _____

Does dental treatment make you nervous? ☐ **No** ☐ **Slightly** ☐ **Moderately** ☐ **Extremely**

Former Dentist's name_____
Address_____
Date of last dental care?_____

Is there anything you don't like about your smile?

_____

_____

MOUTH			**TEETH**		
Bleeding, sore gums	☐ **Y**	☐ **N**	Loose Teeth	☐ **Y**	☐ **N**
Unpleasant taste / bad breathe	☐ **Y**	☐ **N**	Sensitive to hot	☐ **Y**	☐ **N**
Burning tongue / lips	☐ **Y**	☐ **N**	Sensitive to cold	☐ **Y**	☐ **N**
Frequent blisters, lips / mouth	☐ **Y**	☐ **N**	Sensitive to sweets	☐ **Y**	☐ **N**
Swelling / lumps on the mouth	☐ **Y**	☐ **N**	Sensitive to biting	☐ **Y**	☐ **N**
Ortho treatments (braces)	☐ **Y**	☐ **N**	Food impaction	☐ **Y**	☐ **N**
Biting cheeks / lips	☐ **Y**	☐ **N**	Clenching / grinding	☐ **Y**	☐ **N**
Clicking / popping jaw	☐ **Y**	☐ **N**	Shifting of teeth	☐ **Y**	☐ **N**
Difficulty opening or closing jaw	☐ **Y**	☐ **N**	Change in bite	☐ **Y**	☐ **N**

I understand that the information I have given today is correct and accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.

x_____ Date_____

Signature or Patient, Parent or Guardian

First Update

Any Changes:_____

x _____ Date_____

Signature or Patient, Parent or Guardian

Second Update

Any Changes:_____

x_____ Date_____

Signature or Patient, Parent or Guardian

Third Update

Any Changes:_____

x_____ Date_____

Signature or Patient, Parent or Guardian

Please let one of our team members know if there have been insurance or address changes. Thank you

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

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:

Contact Person: Perry Zeeb, DDS

Telephone: 414.272.8866 Fax: 414.272.8831

E-mail: perryz@mkesmiles.com

Address: 735 N Water- Suite 926 - Milwaukee, WI 53202

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 or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Smiles on Broadway

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have seen and/or received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For 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)

_____

_____

_____

Milwukee Smiles, Dr. Perry Zeeb DDS

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 takes effect **April 15, 2003** 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, emails, postcards, 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 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

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.

Contact Officer: **Dr. Perry Zeeb**

Telephone: **(414)272-8866** Fax: **(414)272-8831**

Address: 735 N Broadway, Suite 926 Milwaukee, WI 532022