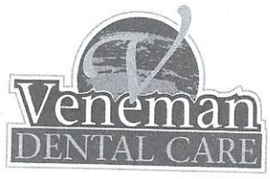
1774 Cope Ave. E, Suite 110
Maplewood, MN 55109
651-770-7175 - (Fax) 651-770-6109



731 Maple Drive, P.O. Box 739
St. Croix Falls, WI 54024
715-483-9705 - (Fax) 715-483-5822

Please answer the following questions. Thank you so much for choosing our office!

Name (Last) (First) (Middle) | Date of Birth / / | Gender M F | Marital Status S M D W DP | Social Security Number

Home Address (Street) (City) (State) (Zip Code) | Home Phone Number ( )

Name of Employer | Occupation | Work Phone Number ( ) | Cell Phone Number ( )

CUSTODIAL PARENT RESPONSIBLE FOR ACCOUNT

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? Yes ☐ No ☐
yes, reason: _____

Are you currently receiving medical care? Yes ☐ No ☐ If yes, nature of care: _____

Are you taking any medication now? Yes ☐ No ☐ If yes, please list the names of the medications and conditions for which they are taken:

1) _____ Taken for _____ 4) _____ Taken for _____
2) _____ Taken for _____ 5) _____ Taken for _____
3) _____ Taken for _____ 6) _____ Taken for _____

Please list all the **Names and Phone Numbers** of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

Are you required to Pre-Medicate with antibiotics before dental treatment? Yes ☐ No ☐
Do you smoke or use tobacco: Yes ☐ No ☐ How many packs per day: _____

Please indicate whether or not your are **allergic** to the following:

Aspirin	Yes ☐ No ☐	Latex	Yes ☐ No ☐
Benzodiazepines (Example: Valium	Yes ☐ No ☐	Metals	Yes ☐ No ☐
Codeine	Yes ☐ No ☐	Penicillin	Yes ☐ No ☐
Dental Anesthitics (Local Anesthetics)	Yes ☐ No ☐	Sulfa	Yes ☐ No ☐
Erythromycin	Yes ☐ No ☐	Tetracycline	Yes ☐ No ☐
Jewelry	Yes ☐ No ☐	**Other**	Yes ☐ No ☐

Have you ever had (please check-mark yes or no for each of the following):

Abnormal Bleeding	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Hepatitus (Type:_____)	Yes ☐ No ☐
Angina Pectons	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐	Joint Replacement (Type:_____)	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Liver Disease (Including Jaundice)	Yes ☐ No ☐
Bleeding Disorder	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐
Cancer (Type:_____)	Yes ☐ No ☐	Migraine Headaches	Yes ☐ No ☐
Chemical Dependency (Type:_____)	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Nickel Allergy	Yes ☐ No ☐
Colitis	Yes ☐ No ☐	Organ Transplant	Yes ☐ No ☐
Congenital Heart Defect	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Chronic Obstructive Pulmonary Disease (COPD)	Yes ☐ No ☐	Previous Biopsies	Yes ☐ No ☐
Coumadin	Yes ☐ No ☐	Psychiatric Problems	Yes ☐ No ☐
Depression	Yes ☐ No ☐	Radiation Therapy	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Recurrent Illnesses	Yes ☐ No ☐
Difficulty Breathing	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Eating Disorder	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Emphysema or Other Respiratory Illnesses	Yes ☐ No ☐	Sleep Apnea	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Slow-Healing Mouth Sores	Yes ☐ No ☐
Fainting Spells	Yes ☐ No ☐	Snoring	Yes ☐ No ☐
HIV - AIDS	Yes ☐ No ☐	Sore/Enlarged Lymph Nodes	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Thyroid Disease	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Heart Surgery	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Heart Valve Replacement	Yes ☐ No ☐	**Other**	Yes ☐ No ☐

Do you consume grapefruit juice, grapefruits or grapefruit extract? Yes ☐ No ☐

Are you taking Tagamet (Cimetidine)? Yes ☐ No ☐ If yes, how often? _____
Do you take Antacids? Yes ☐ No ☐ If yes, how often? _____
Are you taking any herbal or vitamin supplements/medicines? Yes ☐ No ☐
If yes, which ones? _____

Weight: _____ Height: _____

(OVER)

Women: Are you pregnant? Yes ☐ No ☐ If yes, number of weeks: _____
If no, are you planning a pregnancy in the near future? Yes ☐ No ☐
Are you a nursing mother? Yes ☐ No ☐
Are you taking birth control pills or any other prescription birth control? Yes ☐ No ☐

Person to be contacted in case of emergency

Name: _____ Relationship: _____
Address: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Reasons for visit: _____ Approximate date of last dental visit: _____
What is your *primary* concern that you would like us to address first? _____
Name of previous dentist: _____ Location: _____

Are you aware if you clench or grind your teeth while sleeping or during the day? Yes ☐ No ☐
Would you like to have whiter teeth? Yes ☐ No ☐

Please add anything you feel is important: _____

Have you ever had any serious problem associated with previous dental treatment? Yes ☐ No ☐
If yes, please explain: _____

Help us get to know you better. please check the appropriate responses:

When I think about coming to the dentist I feel:
- ☐ Comfortable - I have no anxiety about seeing the dentist or dental procedures
- ☐ Anxious - I don't want to come in but I make myself, however I am seldom comfortable
- ☐ Fearful - I have stayed away from the dentist because of my fear and avoid coming in unless absulutely necessary
- ☐ Extremely fearful - I cannot cope with dental visits and have avoided the dentist for years to the detriment of my dental health

When I think about coming to the dentist I feel:
- ☐ My anxiety and fear
- ☐ Past experiences
- ☐ Cost
- ☐ No time
- ☐ Lack of trust
- ☐ Other _____

My childhood dental experiences were:
- ☐ Completely pain free and comfortable
- ☐ Somewhat uncomfortable
- ☐ Painful
- ☐ Traumatic
- ☐ I did not go to the dentist as a child

My dental experiences as an adult have been:
- ☐ Completely pain free and comfortable
- ☐ Somewhat uncomfortable
- ☐ Painful
- ☐ Traumatic
- ☐ I have not seen the dentist as an adult or my visits have been very few

I have fear of and/or I have concerns about:
- ☐ Experiencing pain
- ☐ Not being numb
- ☐ Needles
- ☐ Unnecessary or wrong treatment
- ☐ Gagging
- ☐ Losing control
- ☐ Having something put over my mouth
- ☐ Being scolded or made to feel ashamed
- ☐ Catching a disease
- ☐ Losing my teeth
- ☐ Having to wear a denture or partial
- ☐ Other _____

The following makes me uncomfortable:
- ☐ The sounds of a dental drill
- ☐ Laying down in a dental chair
- ☐ The smells in a dental office
- ☐ Being numb
- ☐ Having to wait it the reception area
- ☐ Other _____

To understand what's going on in my mouth, my preference is:
- ☐ To know all the details
- ☐ To be given the bottom line
- ☐ To be shown pictures and movies
- ☐ To read pamphlets and brochures
- ☐ To talk with a team member about solutions to my problems

How did you hear about our office? _____

If patient is LESS THAN 18 YEARS OLD, parent or guardian MUST sign

_____
Print Name | Signature | Date | Relationship to patient

Dental Insurance Information

Please provide the office wth your insurance cards so we can make copies.

I certify that I have read and understant the preceding pages and that the information provided is complete and accurate. I understand that payment is my obligation regardless of insurance or any third party involvement. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Veneman Dental Care, P.A. of any changes in my health and medication.

Signature: _____ **Date:** _____

Veneman
DENTAL CARE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- ☐ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirctly.
- ☐ Obtain payment from third party payers.
- ☐ Conduct normal healthcare operations such as quality assessments and physician certificates.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

_____

OFFICE USE ONLY

I attempted to obtain the patients's signature in acknowledgement of our Notice of Privacy Practices on this Notive of Privacy Acknowledgement but was unable to do so as documented below.

Date _____ Name _____ Reason _____

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www.venemandentalcare.com

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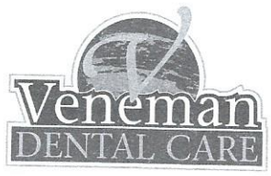

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AN IMPORTANT MESSAGE TO OUR PATIENTS REGARDING FINANCIAL MATTERS

Payment is due in full at time of service.

Payment Options
In order to make dentistry as affordable as possible, we offer you these payment options:

- Pay in full with cash or check at the start of treatment and receive a 5% prompt payment reward.
- Pay in full at time of service with VISA, MasterCard, or Discover.
- For patients with insurance, your *estimated portion* is due at time of service (cash, check, VISA, MasterCard, or Discover).
- Extended-term financing is available through CareCredit or Healthcare Creditline. Please ask us for details.

We include a monthly billing charge of $5.00 or finance charge of 2% whichever is greater on all balances 60 days and older.

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I, without hesitation, agree to pay reasonable collection costs of 29-40% of total debt, and/or attorney fees, if necessary. I have read and understand all of the information contained on this form.

Missed or Cancelled Appointments
There is a minimum $50.00 fee for missed or cancelled appointments without at least **24 hours** notice.

Dental Insurance
It is our pleasure to assist you in managing your insurance benefits. We will assist you in every way to prepare and submit your claims, and to help you maximize your insurance benefits. As a courtesy, we will initially ask you only for your estimated co-payment. Please understand that this is only an estimate, and is based on the information available to us.

The financial obligation for dental treatment is between you and our office, regardless of insurance coverage. Because dental insurance is a contract between you and your insurance company, if we have not received payment from your insurance carrier 30 days after the claim is filed, the remaining balance will be due and payable by you.

Recommended treatment is determined by what is best for your dental health. Our recommendations are based on your dental needs, not your insurance coverage. Your insurance company may or may not cover all recommended procedures. We request that you understand your policy in advance so that together we can make the best treatment decisions. Please remember that dental insurance is not designed to be a pay-all, but merely an assistance.

Our staff is happy to outline estimates and payment with you anytime and answer any special concerns or needs you have.

Patient/Guardian Signature: _____ Date: _____

Rev. 1.30.15

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANDHOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other Individual identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or

coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTEDHEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/@Notice of Privacy Practices.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to
You. (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers 'compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH. INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health &Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

VENEMAN Dental Care:
731 Maple Drive
P.O. Box 739
St. Croix Falls, WI 54024
715-483-9705

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue S.W,
Washington, D.C. 2020
1-877-696-6775 (toll free)

You. (b) For the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers compensation and similar programs any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below. The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to

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