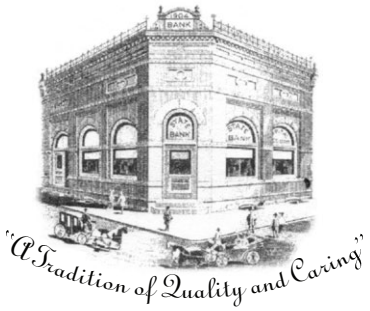

Modern Dentistry In a Historical Setting of Comfort and Style

Gillett Dental Care, S.C.

Evelyn K. Hauser-Frederick, D.D.S.

PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH/ DAY/ YEAR HOME # WORK # CELL#

EMPLOYER _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____

PERSON TO CONTACT IN CASE OF EMERGENCY OUTSIDE OF IMMEDIATE FAMILY HOUSEHOLD:
NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE: ☐SELF ☐GUARDIAN ☐SPOUSE ☐FATHER ☐ MOTHER

INSURANCE INFORMATION

☐ Yes ☐ No If no, please complete 1st box for responsible party

PRIMARY INSURANCE	SECONDARY INSURANCE
LAST FIRST M	LAST FIRST M
ADDRESS	ADDRESS
PHONE: HOME WORK	PHONE: HOME WORK
BIRTHDATE RELATIONSHIP TO PATEINT	BIRTHDATE RELATIONSHIP TO PATEINT
EMPLOYER DENTAL INS. COMPANY	EMPLOYER DENTAL INS. COMPANY
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

Whom may we thank for referring you to our office? _____

AUTHORIZATION

I authorize Gillett Dental Care to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for my insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another health professional.

I hereby authorize payment of insurance benefits directly to Gillett Dental Care, otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

137 East Main Street • Gillett, WI 54124 • P. (920) 855-2155 F. (920) 855-2639

Patient Name _____

MEDICAL HISTORY

Please Circle

Are you under a physician's care now? Why? _____ yes no

Physician's name _____ Phone # _____
Address _____

Have you ever been hospitalized or had a major operation? For what? _____ yes no
Are you taking any medications, pills, drugs or vitamins? What? _____ yes no

_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you allergic to any medications or substances? Please check below _____ yes no

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please Check): ☐ Pregnant ☐ Nursing ☐ Taking fertility medications ☐ Taking oral contraceptives

Do you use Tobacco Products? What kind & amount per day? _____ yes no
Have you noticed any sores or growths in your mouth? _____ yes no

Do you now have or have you ever had any of the following? Please CIRCLE the appropriate response.

- If yes to any of the (*) conditions, please call prior to your appointment….premedication may be needed

Heart Trouble/ Disease	Y N	Lung Disease	Y N	Hepatitis A (Infectious)	Y N	Epilepsy or Seizure	Y N
Heart Murmur*	Y N	Breathing Problems	Y N	Hepatitis B or C	Y N	Fainting or Dizziness	Y N
Irregular Heart Beat	Y N	Shortness of Breath	Y N	Night Sweats	Y N	Glaucoma	Y N
Angina / Chest Pain	Y N	Frequent Cough	Y N	Yellow Jaundice	Y N	Tumors or Growths	Y N
Heart Attack / Failure	Y N	Hay Fever	Y N	Kidney Problems	Y N	Nervousness	Y N
Congenital Heart Disorder	Y N	Sinus Trouble	Y N	Renal Dialysis	Y N	Psychiatric Care	Y N
Mitral Valve Prolapse*	Y N	Asthma	Y N	Thyroid Disease	Y N	Alzheimer's Disease	Y N
Scarlet Fever	Y N	Emphysema	Y N	Parathyroid Disease	Y N	Hives or Rash	Y N
Rheumatic Fever*	Y N	Tuberculosis	Y N	Osteoporosis	Y N	Mental Disability	Y N
Artificial Heart Valve*	Y N	Radiation Treatment	Y N	Arthritis / Gout	Y N	Hearing Problems	Y N
Heart Pace Maker*	Y N	Chemotherapy	Y N	Pain in Jaw Joints	Y N	Vision Problems	Y N
Heart Surgery	Y N	Stomach Problems	Y N	Head / Neck Injuries	Y N	Down's Syndrome	Y N
High Blood Pressure	Y N	Intestinal Disease	Y N	Cortisone Medicine	Y N	Multiple Sclerosis	Y N
Unexplained Fever	Y N	Ulcers	Y N	Artificial Joints*	Y N	Cerebral Palsy	Y N
Bruise Easily	Y N	Acid Reflux	Y N	Venereal Disease	Y N	Bell's Palsy	Y N
Anemia	Y N	Recent Weight Loss	Y N	AIDS	Y N	Autoimune Deficiency	Y N
Excessive Bleeding	Y N	Frequent Urinating	Y N	HIV Positive	Y N	Fybromyalgia	Y N
Hemophilia	Y N	Diabetes	Y N	Drug Addiction	Y N	Head Injuries	Y N
Leukemia	Y N	Excessive Thirst	Y N	Cold Sores	Y N	Malignant Hyperthermia	Y N
Recent Blood Transfusion	Y N	Hypoglycemia	Y N	Herpes	Y N	Emotional Disorder	Y N
Swelling of Ankles	Y N	Liver Disease	Y N	Stroke	Y N		

Have you ever had any other serious illness not listed above? _____ Yes No

Do you wish to talk to the Dentist privately about any problems? _____ Yes No

Additional Comments: _____
_____
_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at the next appointment.

X _____ Date _____ Reviewed By Doctor _____

Doctor's Notes - History Review: _____
_____
_____
_____
_____

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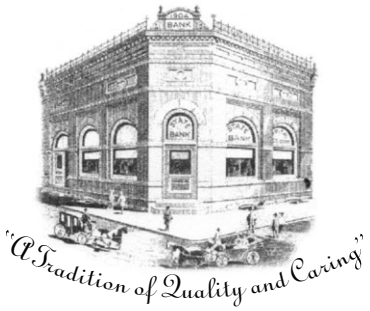

Modern Dentistry In a Historical Setting of Comfort and Style

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Evelyn K. Hauser-Frederick, D.D.S.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to treatment.

As a service to you, we will give you an estimate of the treatment needed. Please remember that this is an estimate only.

Many of our patients are covered by dental insurance. This is a contract **between you and your insurance company**. As a service to you, we will file the claim and send it to your insurance carrier. We will assist in any way we can to give you the maximum benefit you are entitled to. You are, however, responsible for the portion insurance does not cover. **This is due at time of service.** In case your insurance does not pay as much as estimated, the bill is the full responsibility of the patient.

If you bring your child for a visit, you are responsible for the payment. If there is a divorce factor, that is an arrangement you must take responsibility for. Gillett Dental Care will not take any responsibility for notifying and/or billing the other parent. Whoever brings the child in is responsible for all charges accrued that day.

Failure to complete payment of an account will result in the account being turned over to collection, credit bureau, or small claims. The patient is responsible for the full payment of the bill.

Should any special circumstances arise, please feel free to discuss your concerns with our staff.

We **thank you** for trusting us with your dental care needs.

Gillett Dental Care, S.C.

"I have read, understand and agree to the provisions of the Financial Policy."

_____

(Signature of Patient or Person Financially Responsible for the Account) (Date)

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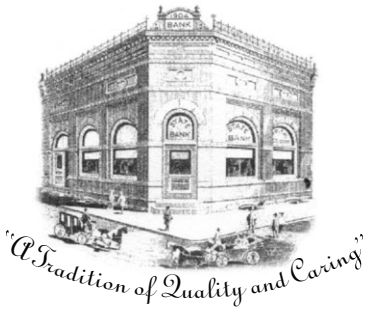

Modern Dentistry In a Historical Setting of Comfort and Style

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Financial Considerations

It is our firm belief that all patients who come to our office want and deserve the finest dental care that can be provided. After years of experience in private practice, we know problems can occur where money is involved. We feel that the best dental care can only be provided when definite financial arrangements are agreed upon. Therefore, our purpose in giving you this sheet is to acquaint you with our financial policy.

In dentistry, we believe that our country is moving to a two-tiered system of care. On the one hand, there is managed-care or some type of insurance-driven system, where a third party is involved in the decisions on what care is rendered as well as in the payment of that care.

The other system is private care. **With private care, the patient and the dentist decide what treatment is appropriate** (even though the patient may receive financial assistance from an insurance entity).

We do not participate in any managed-care or "preferred provider" (such as Delta Dental) programs. **As a service to our patients we do process dental insurance claims.** In the private care model, the patient is responsible for all charges incurred, regardless of what the insurance company or other third party agrees to pay. We believe that this system leads to lower dental costs and healthier patients. **We will always assist you in receiving the maximum coverage to which you are legally entitled from your insurance company.**

Listed is a composite view of the different ways you may take care of your financial responsibilities in our office:

- **Payment is due at time of service unless a written financial agreement has been made in advance.**
- **For our patients with dental benefits:**
  - We ask that you take care of your estimated co-payment at time of service.
  - In accordance with state law, insurance is required to remit payment within 30 days. If no insurance payment has been received within 60 days (even if there is a dispute over the claim), the full balance must be taken care of by any of the payment methods.
- We accept all Major Credit Cards, Debit Cards, cash and personal checks.
- For services totaling in excess of $300.00, we offer the opportunity to take care of the charges over time. You may choose to spread your payment over 90 days **without service charges** by using post-dated checks or authorized credit card charges.
- For our patients who need extended credit terms to achieve their oral health goals you have the option of making arrangements with a local finance institution such as your bank or credit union.

We have a high trust for those we serve and want to help you reach your oral health goals. **Please feel free to discuss your concerns with our staff.**

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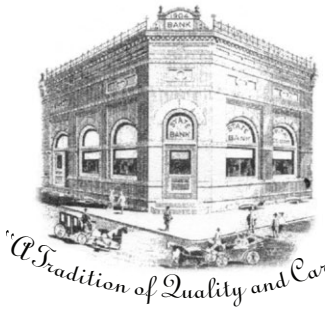

"A Tradition of Quality and Caring"

Modern Dentistry In a Historical Setting of Comfort and Style

Gillett Dental Care, S.C.

Evelyn K. Hauser-Frederick, D.D.S.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

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