RacineDentalGroup s.c.

Dear Parent or Guardian:

My staff and I would like to welcome you and your child to the Pediatric Department of Racine Dental Group, S.C. and thank you for choosing us to provide your child with dental care. We take our responsibility seriously and strive to provide the highest quality dentistry possible while making each visit a pleasurable experience.

Most dental disease is preventable. We focus on helping your child get a healthy start. This is accomplished through education for the child chairside and our discussions with you, the parents. We like to have everyone involved!

Your child cannot prevent disease himself/herself. Good oral hygiene is more than placing a brush on the teeth and wiggling it in the mouth. It requires manual dexterity to effectively clean teeth. This ability is not seen until your child can write his/her name in cursive (8-9 years old).

Please take an active role daily in cleaning your child's mouth. Teeth, gums and tongue all need a gentle brushing at bedtime. Parental involvement is necessary to appropriately get the job done. Consistency impresses on your child that the daily habit is important.

For your convenience, we are enclosing a health history form and a patient registration sheet. Besides saving time in our office, having the forms ahead will enable you to complete them in the comfort of your own home where the necessary information is available.

We are looking forward to your child's visit.

Yours in dental health,
Dr. Jay Oksiuta
Dr. Jenny Quizon

PEDIATRIC OFFICE: 262-637-2911 **FAX:** 262-995-7428 **WEB:** RACINEDENTALGROUP.COM **ADDRESS:** 1101 SOUTH AIRLINE ROAD, RACINE, WI 53406

Feedback Form

RacineDentalGroup s.c.

Smile after beautiful smile since 1969.

How did you hear about us?

New patient? Let us know how you found out about Racine Dental Group. Please check ALL that apply. Not a new patient? Check **"N"** below:

- ❍ **A.** Building sign
- ❍ **B.** Phone book
- ❍ **C.** Search engine (Google, Yahoo, etc.]
- ❍ **D.** Mail promotion
- ❍ **E.** Our website (racinedentalgroup.com]
- ❍ **F.** Newspaper
- ❍ **G.** Event we sponsored _____
- ❍ **H.** Your insurance company _____
- ❍ **I.** Your employer _____
- ❍ **J.** Friend/family referral _____
- ❍ **K.** Dentist/doctor referral _____
- ❍ **L.** Health Care Network/Donated Dental Services
- ❍ **M.** Other _____
- ❍ **N.** Not a new patient

How do you want to hear from us?

Let us know if we can enroll you in our online and automated patient communication system. It will give you the ability to:

- Request and confirm appointments online
- Receive text messages, email and automated phone appointment reminders
- Get dental health updates from our doctors and staff
- Stay up to date on Racine Dental Group news
- Refer your friends and family online

Sound good? Fill in the information and sign/date below to allow us to use your information to communicate with you as described above:

Name _____

Cell phone _____ Home phone _____

Email _____

Signature _____ Date _____

IMPORTANT: We use a third party to provide these communication services. They are required by law to sign a contract agreeing to protect the confidentiality of your Patient Health Information (PHI). Our affiliates do not sell, share or rent our users' personal identifiable information unless required by law, do not send any email or other communication without a user's permission, and do not send spam.

TO OPT OUT: You may opt out of communications at any time by clicking the UNSUBSCRIBE link in an email footer or by replying STOP to a text message. Standard text messaging rates apply.

MAIN (262) 637-9371 **FAX** (262) 637-3071 **WEB** racinedentalgroup.com **ADDRESS** 1101 South Airline Road, Racine, Wi 53406

Patient Registration

RacineDentalGroup s.c.

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Patient information

Name _____

SS # _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

Phone # _____ **Male ○ Female ○**

If patient is a minor: Name of mother _____

Name of father _____

Minor resides with: **Mother ○ Father ○ Both ○ Other ○** _____

Person to notify in case of emergency (other than residence) _____

Relationship _____ Phone # _____

Account information (person responsible for account)

Name _____ SS # _____ Date of birth _____

Relationship _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business address _____ Phone # _____

Spouse's name _____ SS # _____ Date of birth _____

Relationship _____ Phone # _____

Address (if different) _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business address _____ Phone # _____

Dental insurance information

Primary insurance company _____ Phone # _____

Insured's name _____ SS # _____ Date of birth _____

Address _____

City _____ State _____ Zip _____ Effective date _____

Union/local # _____ Group # _____ Member # _____

Secondary insurance company _____ Phone # _____

Insured's name _____ SS # _____ Date of birth _____

Address _____

City _____ State _____ Zip _____ Effective date _____

Union/local # _____ Group # _____ Member # _____

Treatment information

Purpose of visit _____ Is this your first visit to our office? **YES ○ NO ○**

Previous dentist _____ Date of last exam _____

Other family members seen by us _____

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

Please review information on back and sign ➔

Child's Medical History

RacineDentalGroup S.C.

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Name _____

Date of birth _____

Account # _____ Male ○ Female ○

These questions are to help the doctors understand your child better and help us provide the best treatment. Thank you.

Who is your child's physician? _____ Phone # _____

Has your child ever been hospitalized? YES ○ NO ○ If so, when and why? _____

Is your child allergic to any of the following?:

Penicillin/amoxicillin	Y ○ N ○	Sulfa	Y ○ N ○	Augmentin	Y ○ N ○
Erythromycin	Y ○ N ○	Tetracycline	Y ○ N ○	Ceclor	Y ○ N ○
Dental anesthetic	Y ○ N ○	Aspirin	Y ○ N ○	Latex	Y ○ N ○

List any drug or food allergies _____

_____

Is your child taking medications presently? Please list _____

_____

Has your child ever had any of the following?:

Asthma	Y ○ N ○	Down syndrome	Y ○ N ○	Learning disabilities	Y ○ N ○
Birth defects	Y ○ N ○	Epilepsy/convulsions	Y ○ N ○	Liver disease	Y ○ N ○
Bleeding/blood problems	Y ○ N ○	Fainting spells	Y ○ N ○	Psychiatric problems	Y ○ N ○
Cancer	Y ○ N ○	Hearing loss/impairment	Y ○ N ○	Sickle cell anemia	Y ○ N ○
Cerebral palsy	Y ○ N ○	Heart condition/murmur	Y ○ N ○	Skin disorders	Y ○ N ○
Chronic ear infections	Y ○ N ○	Hepatitis	Y ○ N ○	Snoring	Y ○ N ○
Cognitive delay	Y ○ N ○	HIV	Y ○ N ○	Smoking	Y ○ N ○
Delayed speech development	Y ○ N ○	Hyperactivity/ADHD	Y ○ N ○	Tuberculosis	Y ○ N ○
Developmental delay	Y ○ N ○	Joint diseases	Y ○ N ○	Tumors	Y ○ N ○
Diabetes	Y ○ N ○	Kidney disease	Y ○ N ○		

Please explain all yes answers and/or other medical problems not listed _____

_____

Has your child ever had difficult problems associated with previous dental work? YES ○ NO ○

Please explain _____

_____

Diet/snack habits/concerns _____

_____

_____

_____

Because your child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any/all necessary dental treatment be performed by our pediatric dentists.

The signature of the parent or guardian below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill on this child for dental treatment.

Signed _____ Date _____ Signed (Dr./Hyg.) _____ Date _____

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Updated _____	Sig (parent) _____	Sig (Dr./Hyg.) _____
Updated _____	Sig (parent) _____	Sig (Dr./Hyg.) _____
Updated _____	Sig (parent) _____	Sig (Dr./Hyg.) _____
Updated _____	Sig (parent) _____	Sig (Dr./Hyg.) _____

RACINE DENTAL GROUP, S.C. / DIRECT DENTAL SERVICE PLAN, INC.

WISCONSIN CONSENT

SECTION A: INDIVIDUAL GIVING CONSENT

Name: _____

Address: _____

Telephone:_____ E-mail:_____

Patient Number:_____ Social Security Number: _____

Purpose of Consent: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's patient health care records, HIV test results, and mental health treatment 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 form should not be used to obtain written permission for the disclosure of mental health treatment records or HIV test results unless the name of the recipient is listed on this form.

THIS CONSENT ALLOWS US TO TREAT YOU, FILE YOUR CLAIMS, AND STORE YOUR HEALTH INFORMATION IN YOUR CHART AND IN OUR COMPUTERS.

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.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you. This consent allows us to file your claim and to receive payment from your insurance carrier. Without your consent we cannot file your claim.

SECTION B: THE USES AND DISCLOSURES BEING AUTHORIZED.

Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records, mental health treatment records, and HIV test results to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

By signing this form you consent to our disclosure of your patient health care records, mental health treatment records, and HIV test results for disaster relief purposes as permitted by law, including those involved in your care or payment for that care. You also consent to our listing of patient health care information in your chart and on our computer systems. It will only be used for the purpose of treatment, payment activities, and health care operations.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

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 Privacy Practices Notice. Your HIV test results, if any, may be disclosed to persons and/or under circumstances specified in Wisconsin Statutes 252.15 (5) (a). A listing of those persons and/or circumstances is available upon request.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: **Telephone: (262) 637-9371 Fax: (262)637-0576 E-mail: HIPAAPRIVACYOFFICER@RACINEDENTALGROUP.COM**

SECTION C: Revocation: Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed above. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

INDIVIDUAL'S SIGNATURE.

I,_____ , have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent form, I am confirming my written permission for the disclosure of my protected health information, as described in this form **(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.

RACINE DENTAL GROUP, S.C./ RACINE DENTAL PLAN, INC.

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 14, 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.

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- ❍ **F.** Newspaper
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- ❍ **H.** Your insurance company _____
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