PATIENT INFORMATION *DATE*

FIRST NAME **LAST NAME** **MI**

ADDRESS **CITY** **STATE** **ZIP**

HOME PHONE **CELL#**

BIRTHDATE **SS#**

CHECK APPROPRIATE BOX:

SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐

OCCUPATION

EMPLOYER **WORK PHONE #**

EMPLOYER'S ADDRESS **CITY** **STATE** **ZIP**

WHOM MAY WE THANK FOR REFERRING YOU?

PERSON TO CONTACT IN CASE OF EMERGENCY **PHONE**

SPOUSES INFORMATION

FIRST NAME **LAST NAME** **MI**

BIRTH DATE **OCCUPATION** **CELL #**

EMPLOYER **WORK PHONE #**

EMPLOYER'S ADDRESS **CITY** **STATE** **ZIP**

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT **BIRTHDATE**

ADDRESS **PHONE #**

DRIVERS LICENSE # **SS #**

EMPLOYER **WORK PHONE**

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? **YES ☐** NO ☐

PRIMARY DENTAL INSURANCE INFORMATION

INSURANCE COMPANY **PHONE #**

NAME OF INSURED **BIRTHDATE**

SS OR I.D.# **GROUP #**

RELATIONSHIP TO PATIENT

EMPLOYER **PHONE #**

SECONDARY DENTAL INSURANCE INFORMATION

INSURANCE COMPANY **PHONE #**

NAME OF INSURED **BIRTHDATE**

SS OR I.D.# **GROUP #**

RELATIONSHIP TO PATIENT

EMPLOYER **PHONE #**

X

SIGNATURE OF PATIENT **PATIENT NUMBER**

REGISTRATION

FINANCIAL POLICY

Thank you for choosing our office for your dental care. We are committed to the success of your treatment. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment. YOUR CO-PAY & DEDUCTABLE ARE DUE IN FULL AT THE TIME OF SERVICE. To accommodate you, we accept cash, checks, Visa, MasterCard, Discover, and American Express Cards. For extensive treatment plans, we offer extended payment plans with prior credit approval.

Regarding Insurance

We will accept assignment of your insurance benefits. However, we do require your co-payment and deductible to be paid in full at the time of the visit. The balance is your responsibility whether your insurance company pays for your treatment or not. We will gladly process your claims, provided that you give us accurate insurance information. It is your responsibility to inform us of changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable or necessary under your policy. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time the service is provided. We will accept the "allowed amount" as it is stipulated in our contract with the insurance company. However, if a service is not covered, then it is your financial responsibility.

Missed Appointments

Our policy is to charge for missed appointments. Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Please consider your schedule carefully when making appointments.
We require a 24 hour notice for a schedule change. If notice not given:

A broken Hygiene visit will result in a $50.00 charge.
A broken Doctor visit will result in a $75.00 charge

Thank you for taking the time to read and understand our financial policy. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Any of our staff members will be glad to review the financial policy with you at any time.

I have read the Financial Policy. I understand and agree to this financial Policy.

Signature of Patient or Responsible party_____

Date_____

KRAKLOW
QUALITY DENTISTRY

Agreement to Receive Electronic Communication Patient

Name:_____Date of Birth:_____

(Intial below)

I_____DO AGREE

I_____DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

Preferred Phone #_____

Email_____

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

___Text Messaging

___Email

___Both/Either

I would like to receive:

___ Appointment Reminders/Recall Visits

___ Information regarding insurance/billing

___ Request for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling:(414)427-8565

Patient Signature:_____Date:_____

KRAKLOW
QUALITY DENTISTRY

ORAL SCREENING CONSENT FORM

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health to our patients. We are concerned about oral abnormalities (including oral cancer).

One American is diagnosed with oral cancer every 15 minutes. One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and the mortality rate of oral cancer continues to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are the other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors**. Oral cancer risk by patient profile is as follows:

Increase risk: *Patients ages 18 – 39*
Tobacco use
Chronic alcohol consumption
Sexually active patients (age 16-18)
HPV infection, High risk for Oral pharyngeal cancer

High risk: *Patients age 40 and older; tobacco users (any age, any type within 10 years)*

Highest risk: *Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use; previous history of oral cancer)*

We have incorporated **Identafi 3000 Ultra Oral Cancer Technology** into our oral screening standard of care. We find that using **Identafi** along with our comprehensive oral examination improves the ability to identify suspicious areas at their earliest stages. **Identafi** is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. **Identafi** is a simple and painless exam that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of abnormal tissue can minimize or eliminate the potentially disfiguring effects of various lesions including oral cancer and possibly save your life. Although no diagnostic device is fool proof or an absolute guarantee of accuracy, these diagnostic tools do improve our diagnostic abilities. The **Identafi** exam will be offered to you annually.

This enhanced exam is recognized by the American Dental Association code revision committee as CDT procedure Code D0431; however, this exam might not be covered by insurance. The fee for this enhanced examination is **$56.00**.

Yes, I authorize the clinician to perform the **Identafi** exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print Name:_____

Signature:_____ Date:_____

No, I would prefer not to have the **Identafi** Exam at this time:

Print Name:_____

Signature:_____ Date:_____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City: State: Zip:
Occupation:
Height: Weight: Date of Birth: Sex: M F
SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )
If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )
Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?
Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Today's date _____

Your child

Child's Name _____

Nickname _____ Gender _____

Birthdate _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

School _____ *Grade* _____

Responsible Party

Name _____

Relationship to Patient _____

Birth Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Driver's License _____

SS # _____

Employer _____

Work Phone _____

Primary insurance

Insurance Company _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Phone # _____

Insured's Name _____

Relationship to patient _____

Birthdate _____

SS # _____

Employer _____

Occupation _____

Mother Stepmother ☐ Guardian ☐

Name _____

Home Phone _____

Cell Phone _____

Employer _____

Occupation _____

Work Phone _____

SS # _____

Father Stepfather ☐ Guardian ☐

Name _____

Home Phone _____

Cell Phone _____

Employer _____

Occupation _____

Work Phone _____

SS # _____

Additional Insurance

Insurance Company _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Phone # _____

Insured's Name _____

Relationship to patient _____

Birthdate _____

SS # _____

Employer _____

Occupation _____

I.D.# _____ Group # _____

CHILD DENTAL & HEALTH HISTORY

Your child's overall health as well as any medications, which your child takes, could have an important interrelationship with the dental care your child receives.
Please answer each of the following questions completely.

Child's Name_____Date of Birth_____
How often does your child brush?_____How often does your child floss?_____
Previous Dentist_____Date of last dental visit_____
Has your child had difficulty with previous dental visits?_____

	YES	NO
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
Does your child:		
Suck thumb/finger?.	☐	☐
Suck/Bite lip?	☐	☐
Bite/Chew nails?	☐	☐
Chew hard objects (pencils,etc.)?	☐	☐
Grind teeth?	☐	☐
Clench jaws?	☐	☐

Child's Physician_____Phone # _____
Address_____
Previous hospitalizations / Surgeries / Serious Illnesses, and When?

_____

_____

Is your child currently taking medications? YES ☐ NO ☐ If yes, please list._____

_____

Has your child ever taken Fen-Phen/Redux? YES ☐ NO ☐
Does your child have a history of allergies, sensitivities, adverse reactions to any drugs or medications (penicillin, Novocain, etc.? YES ☐ NO ☐ If yes, please explain._____
Does your child have a history of allergies to any other substance (latex, environmental, etc.)?_____

_____

Has your child ever had any of the following:

Asthma	☐ Yes ☐ No	Stomach, liver or kidney problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Handicaps/Disabilities	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No
A persistent cough or throat clearing not associated with a known illness and lasting more than 3 weeks	☐ Yes ☐ No	Abnormal Bleeding	☐ Yes ☐ No
		Convulsions/ Epilepsy	☐ Yes ☐ No

Please explain any medical problems that your child has:_____

_____

Authorization & Release *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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.*

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or Examinations rendered to my child during the period of such care to third party payers and or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2016

THIS NOTICE DESCRIBES HOW 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 MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Jennifer Gapinski
Telephone: (414) 427 – 8565
Fax: (414) 427 – 8590
Email: dds4154@aol.com
Address: 4154 S 108th St. Greenfield, WI 53228

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

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. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

KRAKLOW QUALITY DENISTRY

4154 S. 108th Street, Greenfield, WI 53228

Patient's Name_____

Date_____

ACKNOWLEDGEMENT

I have read the privacy practices of KRAKLOW QUALITY DENTISTRY. I also received a copy of the privacy practice for KRAKLOW QUALITY DENTISTRY.

Signature_____

Date_____

AUTHORIZATIONS

1. I hereby authorize the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. I understand the authorization is voluntary.

   Signature of patient or patient's representative_____

   Date_____

2. Occasionally we take digital photos, x-ray and study casts to help us study, diagnose and properly plan for the treatment of your condition(s). They will further document before and after conditions. I give my permission to KRAKLOW QUALITY DENTISTRY to use these materials in presentations to individuals or groups for the purpose of education or demonstration of dental techniques without recourse or compensation.

   Signature of patient or patient's representative_____

   Date_____

3. Please list the name or names of any person or persons with whom we may discuss your dental health or records other than for the reasons listed above.

   Name_____

   Name_____

   Signature of patient or patient's representative:_____

   Date_____