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___________

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:_____________________

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. This material is for general reference purposes only and does not constitute legal advice. It covers only HIPPA, not other federal or state law. Changes in applicable laws or regulations may require revision. Dentist should contact qualified legal counsel for legal advice, including advice pertaining to HIPPA compliance, the HITEC H Act, and the U.S Department of Health and Human Services rules and regulations.

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 **$60.00**.

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:

	Yes	**No**	**DK**
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?

	Yes	**No**	**DK**
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:

© 2012 American Dental Association
Form S500

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

Kraklow Quality Dentistry

(NAME OF PRACTICE)

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: Dr. Thomas Kraklow

Telephone: 414-427-8565 Fax: 414-427-8590

Address: 4154 S 108th Street, Greenfield WI, 53228

Email: dds4154@aol.com

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. **This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.**

© 2010–2025 American Dental Association. All Rights Reserved.

HIPAA Patient Rights & Acknowledgment

Kraklow Quality Dentistry Effective Date: February 2026

Patient Rights Under HIPAA

Under the Health Insurance Portability and Accountability Act (HIPAA), you have the following rights regarding your Protected Health Information (PHI):

You have the right to:

1. **Receive a copy** of our Notice of Privacy Practices.
2. **Inspect and obtain a copy** of your dental/health records.
3. **Request corrections** to your health information.
4. **Request restrictions** on certain uses or disclosures of your information.
5. **Request confidential communications** (for example, contacting you at a different address or phone number).
6. **Receive an accounting of disclosures** of your PHI.
7. **File a complaint** without fear of retaliation if you believe your privacy rights have been violated.

For questions or complaints, contact:

Privacy Officer: Jennifer G
Phone: (414)427-8565
Address/Email: 4154 S 108th Street, Greenfield 53228 dds4154@aol.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Acknowledgment of Receipt

I acknowledge that I have received or been offered a copy of **Kraklow Quality Dentistry Notice of Privacy Practices**, and I understand my rights under HIPAA.

Patient Name (Print): ____

Patient Signature: ____

Date: ____________________

If signed by personal representative:
Name of Representative: ____
Relationship to Patient: ____