CRESTLINE

Patient's Name _____ Date of Birth ____/____/_____

Gender: Male _____ Female _____ Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please **circle** your responses.

Please describe your current general health: **Excellent** **Good** **Fair** **Poor**

Please describe why you are here today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time: Yes No
If yes, why? _____ Date of Last Physical Exam ___/___/_____

Have you ever been hospitalized, had any surgeries, or had a serious illness? Yes No
If yes, why? _____

_____

_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker, swollen ankles)? Yes No

Can you walk up a flight of stairs without shortness of breath or chest pain? Yes No

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? Yes No

Kidney disease or kidney failure, requiring dialysis? Yes No

Thyroid disease? Yes No

Stomach ulcers or colitis? Yes No

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? Yes No

Frequent or recurring mouth sores? Yes No

Radiation to the head or neck for cancer treatment? Yes No

Osteoporosis or Osteopenia? Yes No

Do you have sleep apnea? Yes No

Do you wear contacts? Yes No

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Yes No

Glaucoma? Yes No

Bleeding disorder, anemia, bleeding tendency, blood transfusion? Yes No

Do you bruise easily? Yes No

Liver disease (jaundice, hepatitis A, B, or C)? Yes No

Diabetes? **Type 1___ Type 2___** Yes No

Arthritis? Yes No

Significant weight loss or gain? Yes No

Seizures, convulsions, epilepsy, fainting or dizziness? Yes No

Sinus or nasal problems? Yes No

HIV Yes No

Any disease, chemotherapy or transplant operation? Cancer?
If so, where? _____. Date of last treatment? _____
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No
If yes, please explain:

_____

_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Anesthesia Complications? Yes No Relationship _____

Diabetes? Yes No Relationship _____

Bleeding problems? Yes No Relationship _____

Tumors? Yes No Relationship _____

Cancer? Yes No Relationship _____

Lung disease? Yes No Relationship _____

FEMALE PATIENTS: Are you pregnant or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following? Please List

Do you need a Pre-Med before dental work? Yes No

Are you on Blood Thinners?_____ Yes No

Antibiotics? _____ Yes No

Heart drugs?_____ Yes No

Steroids (cortisone, prednisone, etc.)?_____ Yes No

Antianxiety agents, sedative-hypnotics and Antidepressants? _____ Yes No

Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?_____ Yes No

Prescription Pain Medication?_____ Yes No
If Yes, Drug Name, How Long, Oral or IV?

_____

Insulin or Oral anti-diabetic drugs?_____ Yes No

High blood pressure medications?_____ Yes No

Bisphosphonates, antiangiogenic and/or Antiresorptive medications for osteoporosis, multiple myeloma, or other cancers?
If yes, list drugs used and time of use. Yes No

_____

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

_____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food Products? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or Ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked? Yes No If yes, how much and for how long? _____

Have you ever chewed tobacco? Yes No If yes, how much and for how long? _____

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How Often? _____

Marijuana? Yes No How Often? _____

Recreational drugs? Yes No How Often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

printed name of patient, parent, guardian Relationship

HEALTH HISTORY UPDATE

Date	Comments	Signature
_____	_____	_____

PATIENT INFORMATION **Current Date** _____

Dr. Mr. Mrs.
Miss. Ms _____ Name _____
First M.I. Last

Address _____ City _____ State _____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Date of Birth _____ Male ____ Female ____ Age ____ Marital Status ____ Pt. SS #_____

Email _____ Occupation _____

Place of Employment/School _____Emergency Contact _____Phone_____

Physician_____ Dentist_____ Orthodontist _____ Referred by _____

Email: _____

FINANCIALLY RESPONSIBLE PARTY (If you are over 18, you are financially responsible)

CHECK if same as above _____ (If checked, skip to next section)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Date of Birth _____ SS # _____

Place of Employment_____ Work Phone _____ Occupation _____ Email_____

The patient is responsible for all fees. It is customary to pay for services when rendered unless other arrangements have been made in advance. I have read this statement and certify that the information is correct.

_____ _____

SIGNATURE OF PATIENT, PARENT or GUARDIAN IF MINOR **DATE**

PLEASE RETURN THIS SIGNED FORM TO THE RECEPTIONIST AT YOUR APPOINTMENT TIME.

ACKNOWLEDGEMENT

I have received a copy of this office's **Notice of Privacy Practice.**

Print Patient Name

▶ _____ _____

Signature of Patient or Parent/Guardian Date

WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

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.

Privacy Practices Notice: You have the right to read our Privacy Practice Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care 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 dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to persons involved in your care and payment for your care. (See sections "To Your Family and Friends" and "Persons Involved in Care" in the Notice of Privacy Practices). 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 dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

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 Privacy Officer listed on the Notice. 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.

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

Print Patient Name

▶ _____ _____

Signature of Patient or Parent/Guardian Date

CRESTLINE

Coulee Region Implant and Oral Surgery Center and Oral Surgery Clinic of La Crosse

NOTICE OF PRIVACY PRACTICES

Revision date 9/13/23

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 Drs. Anderson and Durtsche, Ltd. privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer. Title: Office Manager, Address: 615 S. 10th Street, La Crosse, WI 54601, Email: oa@selectimplants.com, Telephone: 608-784-7319 Fax: 608-784-4384.

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to provide 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 dates 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, and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may discuss 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.

Payment: We provide dental and medical 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 approve the processing of 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:

- health care quality assessment and improvement activities;
- reviewing and evaluating dental and medical 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 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 call and/or send you reminders about your dental care, such as appointment reminders.

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

Public Health and Benefits 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 Restriction 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 preparing any summary or explanation of your medial 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 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.

Restrictions: 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 Communications: 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 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 website 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 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.