Time 8:24 AM

Riverview Community Dental Center

Date 7/23/2015

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes _____

Do you use controlled substances? ◯ Yes ◯ No If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes _____

Comments: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Riverview

My Medicine List - "List it. Don't risk it."

Today's Date

Name

Sex ○ Male ○ Female

Address

Date of Birth

Phone

Doctor name and phone

Pharmacy name and phone

Emergency contact name, phone, relationship

Medicines I should not take and why

Medicine — What happened?

Medicine — What happened?

Medicine — What happened?

Medicine — What happened?

My Medicine List

List all medicines you take. Include prescriptions, vitamins, over-the-counter, supplements, alternative and herbal medicines. Include medicines you got as samples, from the internet, or by mail order.

Name of Medicine and dose	How I take it	Why I take it	Who told me to take it	Date Started	Date Stopped
Example: Aspirin 81mg	*1 pill in the morning*	*Blood*	*Dr. White*	*2005*	*2006*

Notes/Comments

ASPIRUS
Passion for excellence. Compassion for people.

Riverview Dental Clinic
820 Two Mile Ave.
Wisconsin Rapids, WI 54494
Phone# (715)424-8575
Fax# (715)424-8580

Patient Rights & Responsibilities

Aspirus Riverview Community Dental Clinic is committed to respecting the rights and responsibilities of our patients. These rights and responsibilities are recognized as important parts of the care process and are supported by the doctors and staff of this clinic. Patients are expected to uphold their responsibilities as stated if accepted for care.

Patients have rights to the following:

- Impartial reasonable access to care and treatment regardless of one's race, color, creed, religion, age, sex, disability, national origin, marital status, or sources of payment for care.
- Care that is considerate and respectful of their culture and personal beliefs. Interpreters are available.
- Safe practices, a secure environment and freedom from all forms of abuse or harassment.
- Patient and/or legally authorized representative have the right to be informed and make decisions involving their dental care, including the right to accept or refuse dental treatment, and to be informed of the consequences of such refusal.
- Consideration for their personal privacy and confidentiality of information.
- Expect that services rendered meet the standard of care of the dental profession and fall within the guidelines that are set by the medical assistance program.
- Expect that appointments will be scheduled for them on a regular basis until the completion of their care, once they begin the care process providing they have met their obligation of keeping their appointments and arriving on time for these appointments.
- Access to services for urgent care or to obtain a referral if necessary.
- Voice complaints to their care provider, clinic manager or Aspirus Riverview's Patient Advocate at (715)422-9359.

Patients are responsible for the following policies and guidelines affecting care and conduct:

- Providing, to the best of their knowledge, accurate and complete information about their past and current medical status and to report any changes to their medical status.
- Participate in discussions about their plan of care, to ask questions, and to inform the care provider if they do not understand proposed treatment.
- Following treatment plan that they have agreed to and any recommendations for follow-up instructions and/or recommendations for their care.
- Make and keep appointments, arrive on time, stay for the entire time scheduled and provide a minimum of 24 hours notice to change or cancel appointments.
- Make arrangements for childcare or have a responsible person with then to care for a child during a scheduled appointment.
- Patients may not disrupt or interfere with the care provider, or the operation of the care facility.
- Patients may not conduct illegal activities on the premises.
- Refrain from behavior considered harassing (verbal or physical) toward staff or other patients.
- Respect the property of others and that of Aspirus Riverview Community Dental Clinic.

x _____ _____

Patient/Parent or Guardian Signature Date

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PATIENT APPOINTMENT AGREEMENT FORM

Due to the limited amount of open hours Aspirus Riverview Dental (ARD), has in a week and the amount of patients we have waiting to receive services, our clinic policy on no shows has recently been updated. With the unfortunate amount of No Shows we have each week within our Dentist & Hygienist's schedules, the dental clinic will now terminate the relationship with a patient after 2 appointments have been unattended without a 24 hour prior notice.
ARD currently delivers a phoned appointment reminder at least 2 days in advance to each patient's appointment. Our expectation is to have a verbal confirmation from each patient within 24 hours of their appointment. We may have difficulty achieving this because of any of the following:

- Patient's phone number has changed since we made the appointment with them.
- Patient has a voicemail box that is full
- Patient has a voicemail box that has not been set up
- Patient does not return the confirmation call after receiving the message

If we do not have the verbal confirmation received for each patient appointment 24 hours in advance to the appointment, we will take the liberty of scheduling that appointment for any patient on our wait list. If we do not receive a verbal confirmation within 24 hours of the appointment from the patient, this will be counted as a No Show on behalf of the patient.
We require all of our patients to please leave an alternate phone number to give a reminder or direct us to send a reminder by mail. Making sure to call ARD and update any phone or address changes is also beneficial to keeping a good patient appointment status.

I have read and understand the Appointment Agreement at ARD.

X _____ _____

Patient/Parent or Guardian Signature Date

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Wausau, WI

AGREEMENT FOR SERVICES

1. **Medical Consent:** I have come to this Aspirus Hospital or Hospital-Based Clinic ("Aspirus") requesting that I be provided with medical care. **I hereby consent to the rendering of medical care by Aspirus to me during this episode of care.** I understand that this care may include: emergency care and procedures, routine diagnostic procedures, digital imaging and such other medical treatment as my attending physician(s) or other health care providers consider to be necessary. I understand that if any surgery or other specialized treatment is recommended, that I will be advised of this recommendation, given an opportunity to discuss the recommendation and requested to sign a specific consent. I understand that I have the right to refuse medical care and treatment.

2. **No Guarantee of Cure:** I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment by Aspirus. I am not consenting to my care based upon any promise of a particular result or outcome.

3. **Physician as Independent Contractor:** I understand that some physicians on the staff of Aspirus, including my attending physician(s), may not be an employee of Aspirus, but rather, may be independent contractors who have been granted the privilege of using Aspirus facilities for the care and treatment of their patients. Therefore, I understand that I may receive individual billing statements from physicians or a physician group such as radiologists, pathologists, emergency physicians, etc. **In addition to receiving a billing statement from an Aspirus Hospital.**

4. **Healthcare Education:** I understand that Aspirus maintains agreements with academic institutions and that, at times, I may receive a health care service(s) from students acting under the supervision of medical staff members, faculty members or other authorized personnel.

5. **Release of Medical Records:** I understand that Aspirus may release medical information about me to my insurance company including records of 'my diagnosis, treatment and examination rendered during this episode of care for the purposes of 1) assisting me to obtain a determination of my benefits and 2) to facilitate payment of my bills by my insurance company. **I understand Aspirus is not responsible for any decision made by my insurer regarding payment of my bills and that I remain personally responsible to pay any bills or amounts not paid by my insurer.**

6. **An Important Message:** If applicable, I or my legal representative have received **AN IMPORTANT MESSAGE FROM MEDICARE**, or, **TRICARE**, as appropriate.

7. **Personal Valuables:** Patients are encouraged to leave valuables at home including but not limited to jewelry, credit cards, and money. I understand that whereas Aspirus may assist me to secure and store my personal valuables, Aspirus is not responsible nor can it ensure the safety and security of my personal valuables. Therefore, I agree to hold Aspirus harmless from any liability for loss, damage or theft of my personal valuables.

8. **Assignment to Hospital:** In consideration for the medical and health care services rendered or to be rendered to me by Aspirus, I hereby assign to Aspirus the benefits due to me under any applicable insurance that covers or pays for my medical bills and expenses under any basic or major medical plan. I agree to the extent that these benefits are payable to me, they shall be paid directly to Aspirus.

   I agree and understand that, should by benefits under any available basic or major medical plan be insufficient to cover the entire cost or bills from Aspirus for this episode of care, I will be personally responsible to Aspirus for payment of either the entire bill or the remaining balance. It is further agreed that any credit balance resulting from payment of the insurance or other source may be applied to any other account I owe to Aspirus for myself or any other account on which I am a Guarantor (i.e. other family members).

9. **Acknowledgment of Privacy Notice:** I received the Aspirus Notice of Privacy Practices.

   *NOTE: If you received the Aspirus Notice of Privacy Practices during a previous visit, you will not be offered one again.

10. **Acknowledgment of Receipt of Notice to Beneficiary:** Where applicable, I have been informed that I am receiving services at an outpatient department of an Aspirus Hospital. In addition, I have received the Medicare Notice to Beneficiary pamphlet describing what it means to receive services from a department of the hospital including the applicable billing practices.

11. **Notice of Physician Absence:** I have been informed that in-house physician coverage may not always be available at some Aspirus hospital locations. At those times and locations, an on-call physician will be notified and on-site within thirty (30) minutes for evaluation and treatment, as needed.

This form has been explained to me, and I am satisfied that I understand its content and significance.

SIGNATURE OF PATIENT _____ DATE _____ TIME _____

If the patient is unable to sign, or is a minor, complete the following:

Patient is unable to sign because _____

Relationship to patient (Closest Relative or Legal Guardian) _____

SIGNATURE _____ DATE _____ TIME _____

Telephone consent from _____ Date _____ Time _____ Relationship _____

SIGNATURE OF WITNESS _____ DATE _____ TIME _____

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

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Patient Survey

Date: _____

Please check the Race you identify with:

American Indian or Alaskan Native _____

Asian _____

Black or African American _____

Native Hawaiian or Pacific Islander _____

More than one race _____

White _____

Please identify your Ethnicity: Hispanic _____ Non-Hispanic _____

What is your preferred language? _____

Please select the Gender you identify with: Male _____ Female _____

Do you have a disability or a Handicap? Yes _____ No _____

Do you require any special accommodations? _____

_____

_____