Family Health Center
of Marshfield, Inc.
A member of the Marshfield Clinic Health System

Welcome

Your health care is important to our providers and staff.

Welcome to our dental practice. Please review the following information about our practice prior to your appointment. We are dedicated to providing you the best possible dental care experience.

Dental X-ray exams

Your dental visit may include an X-ray exam. Many diseases of the teeth and surrounding tissues cannot be seen when your dentist examines your mouth clinically. An X-ray exam may reveal small cavities between the teeth, infection, tooth abnormalities or some types of tumors. Failure to find and treat these conditions before signs and symptoms have developed can lead to serious oral and general health problems for you. Finding and treating dental problems early can save you time, money and unnecessary discomfort. It may even be life saving.

Child care arrangements

Dental operatories can be an unsafe environment for small children. If you have children, arrange for them to follow their normal activities or stay with a friend or a relative while you are at the dentist.

Appointment rescheduling/no show

We appreciate your effort to keep your appointment. Please provide 24-hour notice if you cannot keep your appointment or need to reschedule your appointment. Please call the dental center where you have your appointment reserved should you need to reschedule your appointment. By doing so, you will help us best serve you and other patients.

If you do not keep your appointment or provide 24-hour cancellation notice, you will be sent a letter notifying you of the no show/late cancellation for an adult patient. If this occurs three times, a final letter will be sent informing you that you will only be seen for emergency needs for approximately one year.

It is our pleasure to serve you for your oral health care needs.

Patient name			
MHN	DOB	Age	Gender

Dental Treatment

Consent

- I hereby authorize the dentist and/or the associates, assistants or dental hygienists to take x-rays, impressions, study models, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of *(name of patient)* _____'s dental needs.
- I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that care provided by a dental hygienist, per the treatment plan, may be performed without a dentist on the premises as allowed by law. Examples of such treatment are: x-rays; prophylaxis (cleaning); sealants; fluoride treatment; root planing and scaling without local anesthesia and periodontal maintenance.
- I consent to the administration of anesthetics and other medications as may be considered necessary and advisable by the dentist. I understand that there are risks and benefits that may occur and are possible in the performance of any procedure. I can ask for an explanation of possible risks and benefits.
- I give consent to the dentist's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations.
- I understand that students in dental care professions may be present or participate in my care under supervision. I also understand, that in the event there is a need for technical support concerning dental equipment or dental supplies, representatives required for that purpose may need to be present in the operatory or procedure room. I consent to their presence.
- I acknowledge that I am responsible and I hereby agree to pay for services provided to me or my dependents by Marshfield Clinic. I understand that payment or co-payment is due at the time of services, unless other arrangements have been made.

This consent is effective for 6 months from the date of signature below.

_____ _____

Patient signature (Person authorized to consent for patient) (Relationship)

_____ ___/___/___ _____

Witness signature Date (month/day/year) Time

White: Medical record Yellow: Patient

Patient name			
MHN	DOB	Age	Gender

Health

Questionnaire

Appointment date (m/d/y) ____ /____ /____ Form completed by: ☐ Self ☐ Other (specify) _____

Reason for visit _____

Name of physician _____ Telephone _____

Address _____

Date of last complete physical (month/day/year) ____ /____ /____

Check (✓) Yes or No or leave blank if you don't know.

	Yes	No
Are you under a physician's care		
If yes, for what _____		
Have you been hospitalized for any operation or surgery		
Describe _____		
_____		
Are you taking any medications (including over-the-counter medicines, vitamins, herbal supplements or natural products).		
If yes, list _____		
_____		
Have you taken or are you scheduled to take oral Fosamax®, Actonel®, Boniva® or intravenous Aredia® or Zometa® for osteoporosis or tumors		
Have you ever been told you need antibiotics or premedication prior to dental treatment		
Are you allergic to or have you had a reaction to:		
Penicillin		
Antibiotics		
Ibuprofen, aspirin		
Codeine or other narcotics		
Local anesthetics (lidocaine, epinephrine)		
Latex (gloves)		
Metal		
Do you have any other allergies		
If yes, list _____		
_____		

Have you had or have at present:	Yes	No
Heart surgery		
If yes, date (m/d/y) ____ /____ /____		
Heart infections, angina		
Artificial heart valve		
Heart attack		
If yes, date (m/d/y) ____ /____ /____		
Heart transplant		
If yes, date (m/d/y) ____ /____ /____		
Heart pacemaker		
Heart murmur		
Congenital heart defect/rheumatic fever		
Taken weight loss drugs (fen-phen, Redux®)		
High blood pressure		
Low blood pressure		
Blood transfusion		
Prolonged bleeding		
Hemophilia		
Anemia (sickle cell) or leukemia		
Stroke		
Epilepsy, seizures		
HIV positive, AIDS		
Respiratory problems		

Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

	Yes	No
Have you had or have at present:		
Hepatitis: ☐ A ☐ B ☐ C		
Chemotherapy/Radiation therapy		
Artificial joint		
If yes, date placed (m/d/y) ____ /____ /____		
Dialysis		
Kidney disease		
Kidney transplant		
If yes, date (m/d/y) ____ /____ /____		
Fainting, dizzy spells		
Panic attacks		
Speech disorder		
Hearing impairment		
Vision impairment		
Glaucoma		
Stomach problems, ulcers		
Eating disorders (anorexia or bulimia)		
Liver disease, jaundice		
Liver transplant		
If yes, date (m/d/y) ____ /____ /____		
Diabetes		
Thyroid disease		
Taken cortisone, steroids		
Asthma		

	Yes	No
Tuberculosis		
If yes, treatment start date ____		
Sinus problems		
Arthritis, rheumatism, systemic lupus		
Cancer		
Sexually transmitted disease		
Use: ☐ Tobacco ☐ Smoke ☐ Chew		
Use alcohol		
If yes, drinks per week ____		
Chemical dependency/drug addiction		
Are you on a pain control/drug contract		
Mental health disorder/psychiatric treatment		
If yes, specify ____		
Orthopedic impairment		
Cerebral palsy		
Muscular dystrophy		
Intellectual disability		
Learning disabilities		
Developmental disorder		
If yes, specify ____		
Women only:		
Taking a birth control prescription		
Are you or could you be pregnant/nursing		
If yes, due date (m/d/y) ____ /____ /____		

Specify any disease, condition or problem not listed above ____

Patient name			
MHN	DOB	Age	Gender

Dental – Format I

Questionnaire

Today's date (month/day/year) ____ /____ /____

Reason for visit _____

Former dentist _____

Address _____

Date of last: Dental exam (m/d/y) ___ /___ /___ X-rays (m/d/y) ___ /___ /___ Cleaning (m/d/y) ___ /___ /___

How often do you: Brush _____ Floss _____

Check (✓) Yes or No or leave blank if you don't know.

	Yes	No
Are you currently in pain		
If yes, where _____		
_____		
_____		
Are your teeth sensitive to:		
Cold		
Hot		
Sweet		
Biting pressure		
Have you had:		
Gum disease		
Bleeding gums		
Loose teeth or food catching between teeth		
Bad mouth odor or bad taste		
Dry mouth		
Frequent cold sores, blisters or ulcers		
Pain in the joint, ear or muscles on the side of face		
Clicking or popping of the jaw		
Difficulty in opening, closing or chewing		
Tired jaws, especially in the morning		
Injury to jaw, head or neck		

	Yes	No
Do you:		
Clench, grit or grind your teeth		
Bite your cheeks or lips		
Bite fingernails or hold pencils, pens or other objects with your teeth		
Mouth breathe		
Snore, have sleep apnea and/or use a CPAP machine		
Have you been treated for:		
Orthodontics (braces)		
Oral surgery (extractions or jaw surgery)		
Periodontics (gum disease)		
Wear denture(s) or partial(s)		
If yes, date(s) made _____		
_____		
_____		
Dental implants placed		
TMJ (jaw joint)		

Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

	Yes	No
Have you had your bite adjusted or do you wear a night guard		
Does your home have well water or do you have a filter for your city water		
Do you take fluoride supplements		
Do you regularly drink sweetened beverages		

	Yes	No
Is it important for you to keep your teeth		
Have you had problems with dental treatment		
If yes, explain _____		

Specify any disease, condition or problem not listed above _____

_____

_____

_____

_____

_____

_____ _____ _____/_____/_____

Patient signature (Patient's legal representative) (Relationship) Date (month/day/year)

Patient name			
MHN	DOB	Age	Gender

Receipt of Privacy Notice Acknowledgement

By signing this form, you acknowledge that you have received a copy of Marshfield Clinic's/Family Health Center's Privacy Notice, which explains how your health information will be handled in various situations. If you have minor children (children under the age of 18) living with you, you also acknowledge by signing this form that you have received this notice on their behalf.

Patient signature (Patient's legal representative) _____ (Relationship) _____ Date (month/day/year) ____/____/____

Patient name		
MHN	Age	Gender

– – Not a medical record document – –

Family Health Center
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Insurance Assignment and Financial Acknowledgement

The following is intended to help our patients understand their financial responsibility for health care services:

Insurance assignment of benefits

Family Health Center may use and disclose your health information to your insurance carrier or its agent, other payers or other persons as necessary for the purpose of obtaining payment for services provided to you.

By providing us your insurance information and allowing us to file claims to your insurance company, you assign to Family Health Center any hospital, medical, dental, surgical and/or mental health benefits you are entitled to under the terms of your insurance policy(ies) or any third-party insurance policy(ies) (such as Workers' Compensation, accident or liability) if any, otherwise payable to you or the policy holder for services rendered by its providers. If you are a Medicare, Medicare Advantage or Tricare beneficiary, your health information is used to determine insurance benefits. Payment of benefits will be made on your behalf to Family Health Center. If you receive a check directly from your insurance company or a third party, it is your responsibility to forward it to Family Health Center for payment.

Financial responsibility

Please understand that your insurance coverage is a contract between you and your insurance company. While we are pleased to be of service by filing claims to your insurance for you, Family Health Center is not responsible for any limitations in coverage that may be included in your plan. When services are not covered by Medicare, Medicaid or any other insurer or other third-party payer, you are ultimately responsible for payment of all charges. You are also responsible for ensuring approvals and authorizations are obtained as required by your insurance.

Please understand that payment is due at the time of treatment if requested or on receipt of a statement unless other arrangements are made with us. Parents or legal guardians are responsible for all fees and services to their minor/child. Credit balances resulting from payments by insurance or other sources may be applied to any account owed the facility naming you as the responsible party.

Patient signature or legal representative of this patient
(If the patient is under 18 years of age, the parent or legal guardian should sign this form)

____/____/____
Today's date (month/day/year)

Relationship to patient
(Power of Attorney or Legal Guardian – documentation should be on file with the center)

MARSHFIELD CLINIC HEALTH SYSTEM

Patient name			
MHN	DOB	Age	Gender

Treatment of Minors in Parent/Legal Guardian Absence

Consent

To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

☐ I/We *(parent's/legal guardian's name)* _____ authorize:

Appointee *(person authorized to consent)* _____

Relationship to patient _____ Appointee's phone number _____

Appointee's address _____

to consent to – check (✓) all that apply:

☐ Emergent or urgent care (including mental health treatment) at Marshfield Clinic Health System and affiliates when I cannot be reached

☐ Medical treatment, mental health treatment or dental care – including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except for a local anesthetic) – at Marshfield Clinic Health System and affiliates

☐ Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic Health System

for my child *(patient's name)* _____

during the period *(not to exceed maximum of 1 year)*:

☐ Date *(month/day/year)* ____ /____ /____ to ____ /____ /____

☐ For a maximum period of 1 year

☐ I/We *(parent's/legal guardian's name)* _____ authorize my driving-age child *(patient's name)* _____ to receive routine care, unaccompanied during the period *(date – month/day/year)* ____ /____ /____ to ____ /____ /____

☐ I/We *(parent's/legal guardian's name)* _____ authorize my child *(patient's name)* _____ to attend physical/occupational therapy appointments unaccompanied during the period *(date – month/day/year)* ____ /____ /____ to ____ /____ /____

☐ Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:

Home phone _____ Work phone _____ Cell phone _____

I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that the minor's insurance does not pay for these services.

_____ _____

Child's parent/legal guardian signature | Relationship to patient

_____ _____ ____ /____ /____

Child's parent/legal guardian address | Parent/Legal guardian phone number | Signature date (m/d/y)

Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consents@marshfieldclinic.org

Additional copy to patient

MARSHFIELD CLINIC HEALTH SYSTEM

Patient name			
MHN	DOB	Age	Gender

Release of Information Authorization

A Patient

Previous last name (if any) | Daytime phone number

Address

City | State | ZIP

B Who has the information that is to be released

☐ Marshfield Clinic Health System, Inc./Family Health Center, 1000 N. Oak Ave., Marshfield, WI Phone: 1-800-782-8581, ext. 7-5687

☐ _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

C To whom the information should be released

Name | Phone number

Attention | Fax

Address

City | State | ZIP

D Medical records or other records to be disclosed

Check (✓) box(es) of the records to be released per this request (if minor is signing this authorization, see section titled "Special medical record release by minor")

Medical records:

☐ Consults ☐ Correspondence ☐ X-ray reports (See Section E)

☐ Medical history and notes ☐ Dental ☐ Surgical reports ☐ HIV/AIDS test results

☐ Laboratory/Pathology reports ☐ Prescriptions ☐ Hospital records ☐ Forms/Opinion reports

☐ Billing/Financial records ☐ Immunizations ☐ School records ☐ Third-party records

☐ By specific doctor, for a specific diagnosis or a specific date range _____

☐ Other, specify _____

Mental health/alcohol & other drug abuse/neuropsychology records:

Specify facility: ☐ Marshfield Clinic Health System ☐ Family Health Center

☐ Mental health AND/OR ☐ Alcohol & other drug abuse AND/OR ☐ Neuropsychology

☐ By specific doctor, for a specific diagnosis or a specific date range _____

☐ Other, specify _____

E Radiology films, pathology slides, or photographs to be disclosed

Check (✓) boxes below for the films, slides or photographs to be released per this request:

☐ Original x-ray of _____ ☐ Mailed date (m/d/y) ____ /____ /____

☐ Photographs (return loaned films/slides within 30 days)

(define type _____) ☐ Pick up date (m/d/y) ____ /____ /____

☐ Pathology slides of _____ By _____

F Method of release

☐ Email (use of encryption required) Email address _____

☐ Paper ☐ Other, specify _____

Note: Information supplied electronically is in PDF format and is encrypted.

Additional copy to patient

Release of Information Authorization (Continued)

Patient name	MHN	DOB	Age	Gender

G **Special medical record release by minor**

I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or any one else.

Check (✓) boxes of medical records to be disclosed:

- ☐ Outpatient alcohol or other drug dependency care (12 years or older) *(parent may also be required to sign below)*
- ☐ Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) *(parent may also be required to sign below)*
- ☐ Rape or sexual assault/abuse (12 years or older) *(parent may also be required to sign below)*
- ☐ Outpatient mental health care (14 years or older)
- ☐ Inpatient mental health care (14 years or older)
- ☐ Neuropsychology notes (14 years or older) *(parent may also be required to sign below)*
- ☐ HIV/AIDS test results (14 years or older)
- ☐ Sexually transmitted disease (17 years or younger)
- ☐ Pregnancy test (17 years or younger) *(parent may also be required to sign below)*
- ☐ Birth control pills or devices (17 years or younger) *(parent may also be required to sign below)*
- ☐ Pregnancy-related care or care of newborn (17 years or younger)
- ☐ Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR) including but not limited to information above *(parent may also be required to sign below)*

Patient signature _____ Date (m/d/y) ____ /____ /____

H **Reason for the release**

Check (✓) box below to indicate the reason for the release per this request:

- ☐ Continuing health care needs
- ☐ Disability
- ☐ Transfer of care
- ☐ Care coordination or case management
- ☐ Second opinion/referral
- ☐ Personal
- ☐ Financial assistance
- ☐ Preemployment or medical evaluation
- ☐ Billing, collection or payment of claims
- ☐ Post-employment testing or medical
- ☐ Employment determination (non-work-related illness or injury)
- ☐ Litigations
- ☐ Other, specify _____

I **Expiration** Check (✓) box to indicate the expiration per this request

This authorization will remain in effect:

- ☐ From the date this authorization is signed until the ____ day of _____, 20 ____
- ☐ Until you cancel this authorization in writing.
- ☐ Until the following event occurs, specify event _____
- ☐ Other, specify _____

Additional copy to patient