



1810 Crooks Ave  
Suite C  
Kaukauna, WI 54130

## Notice of Privacy Practices - Patient Acknowledgement

I have received this practice's Notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information, my individual rights, and this practice's legal duties with respect to my protected health information.

- This practice is required by law to maintain the privacy of protected health information.
- This practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment, and health care operations.
- A description of each of the other purpose for which this practice is permitted or required to use or disclose protected health information without my written consent.
- A description to use or disclose protected health information without my written consent.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights:
  - The right to complain to this practice and to the Secretary of HHS, if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information
  - The right to receive confidential communications of the protected health information
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures or protected health information
  - The right to obtain a copy of the Notice of Privacy Practices

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain the practice's current Notice of Practices of request

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by personal representative of patient): \_\_\_\_\_

## Krupka Dental Financial Policy

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that ALL PATIENTS PAY FOR THEIR TREATMENT IN FULL ON THE DAY OF EACH VISIT to our office unless prior arrangements have been made

**INSURANCE** As a courtesy to you, Krupka Dental will handle all claim submissions to primary and secondary insurance carriers. However, you must provide us with **current** copies of your insurance card(s) and notify us **immediately** when there are any changes in this information. If your carrier has not paid your claim within 45 days of submission, you will be responsible for payment. Any questions regarding your coverage, eligibility and benefits (payments) must be communicated by you directly with your insurance company as you hold the contract with that company. **WE BILL YOUR INSURANCE AS A COURTESY TO YOU.** Please note: The insured is responsible for payment on any claims that are 1)applied to deductible or co-insurance; 2)denied; 3)partially paid; 4)partially paid due to the carrier's arbitrary determination of usual and customary rates.

**COPAYS** are due at the time of service which includes your estimated portion of treatment not covered by your insurance plan.

**NO INSURANCE (Self Pay)** Effective 10/01/2014 anyone without dental insurance can receive a 10% discount if balance is paid in full at the time of appointment. Otherwise, call the patient coordinator to set up a pre-payment plan

**TREATMENT PLANS** We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close *estimate* of your next visits total bill. Please bring cash, check, Visa or MasterCard at the time of treatment. With a proper diagnosis and a timely treatment plan, most *estimates* we provide are accurate

**OUTSTANDING BALANCES** on your account are discouraged, and must be cleared before the next appointment for any member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payments of outstanding balances. Monthly accruing interest at the rate of 1% of the balance\*\***DELINQUENT BALANCES OVER 90 DAYS WILL BE REFERRED TO Finance Systems of Green Bay FOR COLLECTIONS\*\***

**DIVORCE/SEPARATION AND BILLING** We understand that many children live in more than one home because of divorce. We know many issues arise in divorce cases, but our policy is simple. Ultimately, the parent who brings the child in for visits and signs the financial agreement will be considered the responsible party and will receive billing statements.

**A RETURNED CHECK FEE** of \$40(subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check the \$40 fee plus full payment for the check that did not clear must be paid in cash, or by VISA or MasterCard

**CARE CREDIT** Care Credit is a leading patient program that offers you a way to finance your dental needs with interest free programs and payment plans. It offers a convenient way to help you pay for treatments and procedures your insurance doesn't cover- it puts the decision of your care in your hands. It takes only minutes to apply in our office or online.

**I have read the Financial Policy and understand its content. I agree to the terms of the policy**

X \_\_\_\_\_  
PRINT Patient Name

X \_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



We are pleased to welcome you to our practice. This medical history form will help us to better treat you as a patient. Please fill out this as completely as possible.

How did you hear about us?: \_\_\_\_\_

**Patient information:**

Name (First, middle initial, and last): \_\_\_\_\_

Email: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_  Best phone number

Cell phone: (\_\_\_\_) \_\_\_\_\_  Best phone number

Other phone: (\_\_\_\_) \_\_\_\_\_  Best phone number

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

OR

Drivers license number: \_\_\_\_\_

Married  Single  Partnered  Widowed  Minor

I hereby agree and permit Krupka Dental Associates to disclose any medical and/or billing protected healthcare information to the following: (EX: Spouse, parent, child, friend)

Name and relationship: \_\_\_\_\_

Name and relationship: \_\_\_\_\_

Name and relationship: \_\_\_\_\_

Name and relationship: \_\_\_\_\_

**INSURANCE INFORMATION:**

Name of insured person: \_\_\_\_\_

Who is this person employed by: \_\_\_\_\_

Date of birth of insured person: \_\_\_\_\_

Social security number of insured person: \_\_\_\_\_

**Medical history::**

Physician's name: \_\_\_\_\_ Physician's phone: \_\_\_\_\_

Last time you visited your physician: \_\_\_\_\_

Please check any of the following that apply to you:

- Anemia
- Arthritis
- Artificial Heart Valves
- Artificial joints
- Blood thinners
- Cancer
- Chemotherapy
- Diabetes
- Epilepsy
- Glaucoma
- Hepatitis
- Heart problems
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Jaw Surgery
- Kidney Disease
- Liver Disease
- Pacemaker
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sleep apnea
- Snoring
- Thyroid Problems
- Tobacco habit
- Tonsillitis

For staff use only::
----------------------

Have you been hospitalized for any surgeries that were not mentioned in this health history? If yes, please list: \_\_\_\_\_

Is there anything else in your health history you would like us to know? \_\_\_\_\_

**WOMEN::**

Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control:  Yes  No

**Dental history:**

Former dentist: \_\_\_\_\_ Last date of dental care: \_\_\_\_\_

Do you like your smile?  Yes  No

If no, what would you like to change?: \_\_\_\_\_

Do you have a fear of going to the dentist?  Yes  No

- |                                               |                                                        |                                                |
|-----------------------------------------------|--------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Bad Breath           | <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Lost/Broken fillings | <input type="checkbox"/> Sores/growths in mouth        | <input type="checkbox"/> Clenching             |
| <input type="checkbox"/> Sensitivity to hot   | <input type="checkbox"/> Grinding teeth                | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Sensitivity to cold  | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Dental pain           |

Check if you have the following:

How often do you brush?: \_\_\_\_\_ How often to do you floss?: \_\_\_\_\_

Allergies:

---

---

---

---

---

Medications (Currently taking):

---

---

---

---

---

Please state any questions or concerns you have:

By signing this form I am stating that all of the information is filled out to the best of my ability:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_