madisonorthodonticcenters
Thomas P. Kuhn D.D.S. M.S. Board Certified

PERSONAL MEDICAL AND DENTAL REPORT

Patient's name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Birth date: _____ Present age: _____ years _____ months

Name of person preparing this report: _____

Gender: (Please circle) Male Female

General dentist: _____ Physician: _____

Whom may we thank for referring you? _____

Are you under the care of a physician at the present time? (Please circle) Yes No

If so, for what? _____

Have you ever been told by a physician that you need to take medication prior to dental procedures? (Please circle) Yes No

Are any medications currently being taken? Please list medications and the reasons they are used.

_____

Are you allergic to any food, drug, medicine, or specific material?

_____

Have you ever had any injury or blow to the face, mouth, or teeth? _____

Has anyone in your family ever worn braces? _____

Do both parents have a favorable attitude toward having orthodontics done? _____

PATIENT HISTORY OF:

	Yes	No		Yes	No
Arthritis	☐	☐	Hemophilia/Abnormal Bleeding	☐	☐
Artificial Bones/Joints	☐	☐	Hepatitis	☐	☐
Artificial Heart Valve/Pacemaker	☐	☐	High/Low Blood Pressure	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐
Cancer/Chemotherapy	☐	☐	Kidney Problems	☐	☐
Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐
Epilepsy/Seizures/Fainting Spells	☐	☐	Rheumatic Fever	☐	☐
Genetic Disorders	☐	☐	Severe/Frequent Headaches	☐	☐
Heart Attack/Stroke	☐	☐	TMJ (Jaw Joint) Popping/Soreness	☐	☐
Heart Murmur	☐	☐	STD (Sexually Transmitted Disease)	☐	☐

Please comment on any "yes" answers. If more space is required, please write on the back of this form.

_____

_____

_____

Madison Orthodontic Centers
Dr. Thomas P. Kuhn
6105 Monona Dr
Monona, WI 53716
608-663-8819 Fax 608-661-8257

TO OUR PATIENTS WITH ORTHODONTIC INSURANCE:

Our office is happy to cooperate with patients who are covered by orthodontic insurance. Dental insurance policies do not necessarily include benefits for orthodontic treatment. Please read your policy carefully to be fully aware of its benefits as well as its limitations. Should you still have questions about your coverage, please contact the Employee Benefits Office at your place of employment. Our business office will file your claims. We ask that you complete this insurance form and bring it to your consultation appointment. This information will be placed in our computer and any charges will be sent to your insurance company. **If you do not complete this form we cannot file your insurance. It will be your responsibility to pay any balance not covered by your orthodontic insurance benefits.**

Patient's Name:_____

Birthdate:_____ Gender (Please circle) Male Female

Relationship to Employee: Self___ Spouse____ Child___ Stepchild____ Other_

PRIMARY INSURANCE

Name of Employee:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Birthdate:_____ Member ID# / Social Security#_____

Name of Insurance Company:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Insurance Company phone #:_____ Group #:_____

Name of Employer:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.
Signed (Insured Person)_____Date:_____

If there is more than one insurance benefit, please complete the back of this form.

SECONDARY INSURANCE

Patients relationship to Employee: Self___ Spouse____Child____Stepchild___ other ____

Name of Employee:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Birthdate:_____ Member ID# /Social Security #_____

Name of Insurance Company:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Insurance Company phone #:_____ Group #:_____

Name of Employer:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.
Signed (Insured Person)_____Date:_____

If there is additional insurance coverage, please list detailed information below.

MADISON ORTHODONTIC CENTERS

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with Dr. Thomas Kuhn in person or by phone at 608-663-8819.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Patient's Name: _____

Patient/Responsible Party Signature (If under 18): _____

Date: _____

Madison Orthodontic Centers

COVID-19 Pandemic-Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	YES	NO
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Have you recently lost or had a reduction in your sense of smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting the results?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus, or train within the past 14 days?		
Have you experienced any cold or flu-like symptoms in the last 14 days including sneezing, watery eyes, sinus pain/pressure, gastrointestinal problems, headache, fatigue? (Disregard seasonal allergies)		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____

Patient Name

_____ _____

Parent/Guardian-Print Name (If patient is under 18) Relationship to Patient

_____ _____

Patient/Parent/Guardian Signature Date

Madison Orthodontic Centers
SUPPLEMENTAL
INFORMED CONSENT
Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

❑ YES
❑ NO

_____
Patient Name

_____ _____
Parent/Guardian-Print Name (*If patient is under 18)* Relationship to Patient

_____ _____
Patient/Parent/Guardian Signature Date

Patient Name: _____

Madison Orthodontic Centers Informed Consent

Informed consent indicates your awareness of the negative as well as positive aspects of orthodontic treatment. This includes your understanding of the diagnosis and purpose of proposed treatment, risks, treatment alternatives and prognosis if there is no treatment.

To begin, it is important to understand that Dr. Kuhn is not obligated to treat everyone who seeks treatment. There are multiple elements considered before treatment is proposed. One primary consideration is "what are the patients/parent expectations?" Can we meet your expectations? We do not promise or guarantee a "perfect" result. We only promise that we will give our best effort to obtain the best possible result in a reasonable length of time. At the treatment conference we explain our proposed orthodontic treatment. However, I feel to list and explain the unfavorable aspects is helpful and informative as well. Risks include, but are not limited to:

1. Root resorption is a reduction of root surface or root length of certain teeth. If root resorption does occur during orthodontic treatment, in the great majority of patients it does not jeopardize the health, function, longevity, or appearance of the teeth. It must be remembered that this unusual phenomenon can occur in individuals that have never had orthodontic treatment. Hormonal imbalances, especially in older patients, may be a contributing factor.

2. The decaying of teeth with braces on them results from poor oral hygiene. This decalcification of the enamel shows up as white areas of enamel. This can be prevented by the careful brushing of braces, teeth, and gingival tissue as directed. The avoidance of sweets, soda pop, and candy is also recommended. Please continue to see your family dentist every 6 months for routine dental care.

3. Periodontal disease can also result from poor oral hygiene. Of course, this problem will not occur if the teeth and gingival tissue are carefully brushed. Extremely poor oral hygiene may result in receding gums and gradual loss of supporting bone for your teeth.

4. On rare occasions, the nerve of a tooth can undergo regression and may become non-vital as a consequence of pressure of orthodontic braces. This may also result from trauma to the tooth such as blows, falls, or being hit by an object. Nerve degeneration may require root canal therapy to maintain the health of the tooth.

5. In some instances, and here again the incidence is infrequent, the patient presents some problems with the joint of the lower jaw. This joint is called the temporomandibular joint. This is manifested by clicking or pain in the joint upon opening or closing the jaw. There may also be pain in the facial and oral muscles. These symptoms can also be present in individuals who are not undergoing orthodontic treatment.

6. Teeth shift during the lifetime of any individual regardless of orthodontic treatment. With orthodontic treatment there are normal changes in positioning of the teeth following active treatment. I make every effort to prevent unwanted relapse by proper treatment and long-term retention.

7. Pre-existing conditions do exist which may preclude an accurate skeletal and occlusal pattern from being identified. These physical accommodations sometimes mask the true nature or the full extent of the problem. As a consequence, treatment plans are sometimes modified during the course of treatment; including the potential for orthognathic surgery... especially in those patients exhibiting abnormal jaw growth.

8. Gum tissue reacts to braces and treatment in different ways. If dental hygiene is satisfactory, there will be minimal change. But sometimes the gum tissue becomes very swollen and/or inflamed requiring the removal of braces... in almost all cases the gum tissue will then return to normal.

9. Length of treatment is variable. You have been given our best estimate. We have no reason to lessen the predicted duration. However, abnormal jaw growth, poor hygiene, poor cooperation, broken appliances and missed appointments can extend treatment and affect the quality of the results.

It is critical and very important that you understand:

What is the probable treatment prognosis?

What are alternative treatment choices?

What are any foreseeable complications?

The patient/parents have a right to refuse treatment.

Perfection may be our goal, but in dealing with problems of growth and development, genetics and the environment, as well as patient cooperation as we do in orthodontics, adequacy may be a necessary standard. No practitioner of medicine or dentistry can guarantee any result but can only indicate that they will attempt to resolve the particular problem to the best of their ability. We will provide a safe and infection-controlled environment and treat the patient with respect. To this end you have my assurance.

I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND HAVE THOSE QUESTIONS ANSWERED.

Your signature on this form authorizes orthodontic treatment and defines your awareness of informed consent.

Signature Date

Witness Date

madisonorthodonticcenters
Thomas P. Kuhn D.D.S. M.S. Board Certified

6105 Monona Drive, Monona, WI 53716
(608) 663-8819 • Fax (608) 661-8257

HEALTH CHECK EXAM REFERRAL FORM

RECIPIENT NAME: _____

***Date of most recent <u>Health Check Exam</u>**: _____

The Health Check Exam must have been completed within the last 12 months. If not, a new Health Check Exam must be performed.

Referral for Orthodontic Treatment

PHYSICIAN NAME: _____ PHONE: _____
(not dentist) Please print

PHYSICIAN SIGNATURE: _____ **DATE**: _____
Signature and date required

BRING THIS COMPLETED FORM TO YOUR ORTHODONTIC APPOINTMENT

DO NOT FAX OR MAIL