PRACTICE LIMITED TO
PERIODONTICS AND DENTAL IMPLANTS

Cynthia T. Jarzembinski, D.D.S., M.S.

Circle One: ◯ Miss ◯ Ms. ◯ Mrs. ◯ Mr. ◯ Dr. How do you wish to be addressed? _____

Last Name	First	Birth Date Month/Day/Yr.	Height	Weight	Marital Status
Mailing Address		City	State	Zip	Home Telephone
Name and Address of Your Place of Employment					Business Telephone
Your Social Security No.	Name of Spouse or Parent			Person Responsible for Account, if Other than Yourself	
Referred by					Name of General Practitioner

YOUR ASSISTANCE WITH THIS INFORMATION WILL AID US IN YOUR CASE.

MEDICAL HISTORY: Circle One

Name of Physician: _____

Are you presently under the care of a physician? Yes No
What are you being seen for? _____

Are you presently taking any medications? Yes No
Please list them and state why. _____

_____

_____

Are you taking Aspirin daily? Yes No

Have you ever had to use Bisphophonates for chemotherapy or osteoporosis now or in your past? These drugs include:(Fosamax,Ostac, Skelid, Zometa, Didronel, Boniva, Bonefos, Aredia, Actonel.) Yes No

Are you allergic to or have you had an adverse reaction to any medication or substance? If so, please indicate the medication and the reaction you had. Yes No

_____

Are you allergic to latex? Yes No

Have you ever had rheumatic fever, heart murmur or mitral valve prolapse? Yes No

Have you ever been treated for or been told you might have any heart disease or coronary artery disease? If so, please describe. _____ Yes No

Do you have any other condition we should be aware of? Yes No

Do you have artificial joint replacements or heart valve implants? If so, describe. When were they placed? _____ Yes No

Do you premedicate with an antibiotic for any dental procedures? Yes No

Do you use tobacco in any form? If so, how much? _____ Yes No

Have you tested positive for the HIV virus? Yes No

Is there anything about your health you would like to discuss privately with the doctor? Yes No

For females:

Are you pregnant? Yes No

Are you taking birth control pills? Yes No

Do you have or have you ever had:

Abnormal bleeding from a cut, or bruise easily? Yes No

Abnormal blood pressure? Yes No

Fainting Spells? Yes No

Epilepsy or seizures? Yes No

Abnormal thyroid condition? Yes No

Diabetes? Yes No

Radiation Treatment for any purpose? Yes No

Hepatitis? Yes No

Asthma? Yes No

Alcohol or other drug dependency? Yes No

Depression? Yes No

DENTAL HISTORY:

Is there any area of your mouth causing discomfort at this time? If so, where? _____ Yes No

Would you be extremely disturbed if you were to lose your teeth and have to wear dentures? Yes No

Have you ever had periodontal (gum) treatment? If so, when and by whom? _____ Yes No

Are you aware of clenching and/or grinding teeth, especially when tired, tense, or asleep? Yes No

Have you had orthodontic treatment? (braces) Yes No

When was your last teeth cleaning? _____

Wisconsin statue provides that patients or their authorized agents have the right to inspect their dental records. This may be done during our business hours provided advance notice has been given and a signed consent form has been submitted. A fee will be charged to defray copying costs. Upon request, we will provide the necessary forms.

I understand that my dental or health care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all charges relating to this treatment.

Signature: _____

Date: _____

INSURANCE INFORMATION SHEET

DATE:_____

THOROUGH COMPLETION OF THIS FORM WILL ENABLE US TO OBTAIN MAXIMUM INSURANCE COVERAGE FOR YOUR TREATMENT.

NAME OF PERSON
CARRYING INSURANCE:_____ SELF ☐ SPOUSE ☐

SOCIAL SECURITY #: _____ BIRTH DATE OF INSURED: _____

NAME OF EMPLOYER:_____

ADDRESS OF EMPLOYER: _____

PRIMARY DENTAL INSURANCE **NO DENTAL** ☐

INSURANCE COMPANY: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ EFFECTIVE DATE:_____

SUBSCRIBER NUMBER:_____ GROUP #:_____

PRIMARY MEDICAL INSURANCE **NO MEDICAL** ☐

INSURANCE COMPANY:_____

ADDRESS:_____

TELEPHONE NUMBER:_____ EFFECTIVE DATE:_____

SUBSCRIBER NUMBER:_____ GROUP #_____

SECONDARY DENTAL INSURANCE **NONE**_____

INSURANCE COMPANY & ADDRESS_____

NAME OF PERSON
CARRYING 2ND INSURANCE:_____ BIRTHDATE_____

SUBSCRIBER#_____ GROUP#_____
NAME & ADDRESS OF EMPLOYER:_____

SECONDARY MEDICAL INSURANCE **NONE:**_____

INSURANCE COMPANY & ADDRESS:_____

NAME OF PERSON
CARRYING 2ND INSURANCE_____ BIRTHDATE:_____

SUBSCRIBER NUMBER: _____ GROUP#:_____
NAME & ADDRESS OF EMPLOYER:_____

DR. CYNTHIA T. JARZEMBINSKI

WISCONSIN CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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

SECTION A: INDIVIDUAL GIVING CONSENT.

NAME:_____
(PLEASE PRINT)

TO THE INDIVIDUAL: Please read the following and complete the information required.

Effect of Declining Consent: **This consent is a condition of your treatment by us. If you decide not to sign this consent, we may (1) decline to treat you, (2) ask for payment at time of service, as we are unable to file your insurance claims and (3) prohibits us from giving you a safe and high standard of care.**

Privacy Practice 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 Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION B: THE USES AND DISCLOSURES BEING AUTHORIZED.

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

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, letters, answering machines, spouses, significant others, secretary and other family members). Also, we may identify our office when contacting you by any of the above mentioned examples..

We may use professional judgement 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 prescriptions, 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 patient health care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

OVER

PAYMENT AUTHORIZATION:

I HEREBY AUTHORIZE INSURANCE PAYMENTS COVERING THE COST OF MY TREATMENT TO BE MADE DIRECTLY TO DR. JARZEMBINSKI. A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

SECTION C: REVOCATION.

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 Contract Office listed below. 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 to treat you if you revoke this consent.

CONTACT OFFICE: Dr. Cynthia T Jarzembinski

TELEPHONE:	(414) 352-8887
ADDRESS:	6944 North Pt. Washington Road Milwaukee, WI 53217
FAX:	(414) 352-5566

INDIVIDUAL'S SIGNATURE.

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 and give my permission to identify the office name when contacting you.

Signature: _____ **Date:** _____

If a personal representative, on behalf of the individual, signs this consent, complete the following:

Personal Representative's Name _____
(PLEASE PRINT)

Relationship to Individual _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If you would like a copy of this form, please ask.

CYNTHIA T. JARZEMBINSKI, D.D.S., M.S.
Practice Limited to Periodontics

PAYMENT AUTHORIZATION:

I hereby authorize Insurance Payments covering the cost of my treatment to be made directly to Dr. Jarzembinski.

These benefits would otherswise be payable to me requiring my reimbursement to the above said doctor.

_____
(Signature of Insured Person)

_____
(Date)

This signature is valid for two years from the above date, unless revoked earlier by me.

RELEASE OF INFORMATION:

Dr. Jarzembinski is authorized to provide any insurance company information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating the administering claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever comes first.

I know I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

_____
(Patient or Authorized Person's Signature)

_____
(Date)

CYNTHIA T JARZEMBINSKI, D.D.S., M.S.

PRACTICE LIMITED TO PERIODONTICS
DENTAL IMPLANTOLOGY

I GIVE PERMISSION FOR MY MINOR SON/DAUGHTER TO BE TREATED BY DR. CYNTHIA JARZEMBINSKI.

DATE: _____

I ALSO ACCEPT TOTAL RESPONSIBILITY FOR ALL FEES REGARDLESS OF

INSURANCE COVERAGE.

_____
MINOR'S NAME

_____
GUARDIAN'S SIGNATURE

DATE _____

6944 N. Port Washington Road * Milwaukee, WI 53217 * Telephone (414) 352-8887 * Fax (414) 352-5566
W64 N728 Washington Avenue * Cedarburg, WI 53012 * Telephone (262) 377-1664 * Fax (262) 377-6603
N96 W18221 County Line Road * Meno Falls, WI 53081 * Telephone (262) 250-9887 * Fax (262) 250-7754