

NEW PATIENT FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.)	DOB	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor		
How did you hear about us?		

CONTACT INFORMATION			DENTAL INSURANCE 1 st COVERAGE		
Street Address			Employee Name		
City	State	Zip	Date of Birth		
Phone numbers	Home	Cell	Relationship to patient		
	Work	Other	Employer name		
Email			Name of Insurance Co		
Divers License Number			Address		
Social Security Number			City	State	Zip
Other family members at Mueller Dental			Phone number		
Method of Payment <input type="checkbox"/> Insurance <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card			Program or policy #		
			Social Security Number		
Patient/Parent Employer			Union Local or Group		
Present position					
How long held? <input type="checkbox"/> month(s) <input type="checkbox"/> year(s)					
Business Address			DENTAL INSURANCE 2nd COVERAGE		
City	State	Zip	Employee Name		
Spouse/Parent Name			Date of Birth		
Spouse/Parent Employer			Relationship to patient		
Present position			Employer name		
How long held? <input type="checkbox"/> month(s) <input type="checkbox"/> year(s)			Name of Insurance Co		
Business Address			Address		
City	State	Zip	City	State	Zip
			Phone number		
			Program or policy #		
			Social Security Number		
Relationship			Union Local or Group		

EMERGENCY CONTACT		
Name		
Relationship	Phone number	

CONSENT I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and healthcare operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care _____.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of benefits may pay less than the actual bill for services, and that I am financial responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreement to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's signature _____ **Date** _____

DENTAL HISTORY FORM

	Comments
Purpose of your initial visit	
Are you aware of any problem(s)?	
Previous dentist name and address	
How long since your last dental visit? <input type="checkbox"/> month(s) <input type="checkbox"/> year(s)	
What was done at that visit?	
When was the last time your teeth were cleaned?	
Have you had regular visits? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
How often?	
Were dental x-rays done? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Have you lost any teeth or have any teeth been removed? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Why?	
Have they been replaced? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
How have they been replaced?	
Fixed Bridge Age Denture Age Removable Denture Age Implant Age	
Are you unhappy with the replacement? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
If yes, explain	
Would you like to know about permanent replacements? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Have you ever had problems or complications with previous dental treatment? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
If yes, please explain	
Do you clench or grind your teeth? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Does your jaw click or pop? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Have you experienced any pain or soreness in the muscles of your face or around your ear? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Do you have frequent headaches, neckaches or shoulder aches? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Does food get caught in your teeth? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Are any of your teeth sensitive to <input type="checkbox"/> Hot ? <input type="checkbox"/> Cold? <input type="checkbox"/> Sweets? <input type="checkbox"/> Pressure?	
Do your gums hurt or bleed? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Why?	
Do you experience dry mouth? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
How often do you brush your teeth? When?	
Do you use dental floss? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
How often?	
Are any of your teeth loose, tipped, shifted or chipped? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Are you unhappy with the appearance of your teeth? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
How do you feel about your teeth in general?	
Do you feel your breath is offensive at times? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Have you ever had gum treatment or surgery? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
What?	
Where?	
When?	
Have you ever had orthodontic work? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?	
Do you have any questions or concerns? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	

I certify that the above information is complete and accurate

Patient's/Guardian's signature _____ Date ____/____/____

Dentist's signature _____ Date ____/____/____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

		If yes, please explain here
Are you under a physician's care now?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever had a serious head or neck injury?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Are you taking any medications, pills, drugs or vitamins?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you take, of have you taken, Phen-Fen or Redux?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Are you on a special diet?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you use tobacco?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you use controlled substances?	<input type="checkbox"/> yes <input type="checkbox"/> 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 allergies:

Do you have, or have you had, any of the following?			
AIDS/HIV positive <input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	Hemophilia <input type="checkbox"/> yes <input type="checkbox"/> no	Radiation treatment <input type="checkbox"/> yes <input type="checkbox"/> no
Alzheimer's disease <input type="checkbox"/> yes <input type="checkbox"/> no	Drug addiction <input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis A, B or C <input type="checkbox"/> yes <input type="checkbox"/> no	Renal dialysis <input type="checkbox"/> yes <input type="checkbox"/> no
Anaphylaxis <input type="checkbox"/> yes <input type="checkbox"/> no	Easily winded <input type="checkbox"/> yes <input type="checkbox"/> no	Herpes <input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic fever <input type="checkbox"/> yes <input type="checkbox"/> no
Anemia <input type="checkbox"/> yes <input type="checkbox"/> no	Emphysema/COPD <input type="checkbox"/> yes <input type="checkbox"/> no	High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatism <input type="checkbox"/> yes <input type="checkbox"/> no
Angina <input type="checkbox"/> yes <input type="checkbox"/> no	Epilepsy/seizures <input type="checkbox"/> yes <input type="checkbox"/> no	High cholesterol <input type="checkbox"/> yes <input type="checkbox"/> no	Seasonal allergies <input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis/Gout <input type="checkbox"/> yes <input type="checkbox"/> no	Excessive bleeding <input type="checkbox"/> yes <input type="checkbox"/> no	HPV/genital warts <input type="checkbox"/> yes <input type="checkbox"/> no	Shingles <input type="checkbox"/> yes <input type="checkbox"/> no
Artificial heart valve <input type="checkbox"/> yes <input type="checkbox"/> no	Excessive thirst <input type="checkbox"/> yes <input type="checkbox"/> no	Hypoglycemia <input type="checkbox"/> yes <input type="checkbox"/> no	Sinus trouble <input type="checkbox"/> yes <input type="checkbox"/> no
Artificial joint <input type="checkbox"/> yes <input type="checkbox"/> no	Fainting spells/dizziness <input type="checkbox"/> yes <input type="checkbox"/> no	Irregular heartbeat <input type="checkbox"/> yes <input type="checkbox"/> no	Spina bifida <input type="checkbox"/> yes <input type="checkbox"/> no
Asthma <input type="checkbox"/> yes <input type="checkbox"/> no	Fibromyalgia <input type="checkbox"/> yes <input type="checkbox"/> no	Kidney problems <input type="checkbox"/> yes <input type="checkbox"/> no	Stents/shunts <input type="checkbox"/> yes <input type="checkbox"/> no
Autism spectrum <input type="checkbox"/> yes <input type="checkbox"/> no	Frequent cough <input type="checkbox"/> yes <input type="checkbox"/> no	Liver disease/jaundice <input type="checkbox"/> yes <input type="checkbox"/> no	Stomach/Intestinal disease <input type="checkbox"/> yes <input type="checkbox"/> no
Blood disease <input type="checkbox"/> yes <input type="checkbox"/> no	Frequent headaches <input type="checkbox"/> yes <input type="checkbox"/> no	Low blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Stroke <input type="checkbox"/> yes <input type="checkbox"/> no
Blood transfusion <input type="checkbox"/> yes <input type="checkbox"/> no	Genital herpes <input type="checkbox"/> yes <input type="checkbox"/> no	Lung disease <input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid disease <input type="checkbox"/> yes <input type="checkbox"/> no
Breathing problems <input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma <input type="checkbox"/> yes <input type="checkbox"/> no	Mental illness <input type="checkbox"/> yes <input type="checkbox"/> no	Tonsillitis <input type="checkbox"/> yes <input type="checkbox"/> no
Cancer <input type="checkbox"/> yes <input type="checkbox"/> no	Hay fever <input type="checkbox"/> yes <input type="checkbox"/> no	Mitral valve prolapse <input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
Chemotherapy <input type="checkbox"/> yes <input type="checkbox"/> no	Hearing impaired <input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis <input type="checkbox"/> yes <input type="checkbox"/> no	Tumors or growths <input type="checkbox"/> yes <input type="checkbox"/> no
Chest pains <input type="checkbox"/> yes <input type="checkbox"/> no	Heart attack/failure <input type="checkbox"/> yes <input type="checkbox"/> no	Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no	Ulcers <input type="checkbox"/> yes <input type="checkbox"/> no
Cold sores/Fever blisters <input type="checkbox"/> yes <input type="checkbox"/> no	Heart murmur <input type="checkbox"/> yes <input type="checkbox"/> no	Parathyroid disease <input type="checkbox"/> yes <input type="checkbox"/> no	Venereal disease <input type="checkbox"/> yes <input type="checkbox"/> no
Congenital heart disorder <input type="checkbox"/> yes <input type="checkbox"/> no	Heart trouble/disease <input type="checkbox"/> yes <input type="checkbox"/> no	Parkinson's disease <input type="checkbox"/> yes <input type="checkbox"/> no	Vision impaired <input type="checkbox"/> yes <input type="checkbox"/> no

Have you ever had any serious illness not listed above? yes no

If yes, please explain:

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.

Patient's/Guardian's signature _____ Date ____/____/____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 02/16/2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: we must disclose your health information to you, as describe din the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. IF you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization except as follows: minimally identifying dental photos (photos of teeth, radiographs or smile) may be utilized for marketing, education, lecture, credentialing or social media.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, emails, postcards, or letters). IF this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

SUD Treatment Information: If we receive or maintain any information about you from a substance use disorder treatment

program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment, and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you for each page, to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure accounting: You have the right to receive a list of instance in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing)**. Your request must specify the alternative means or locations, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances. You can make this request in person at the address listed below or by mail or fax to the address or number listed below.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy or have questions or concerns, please contact us. You will find our contact information at the end of this document.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. Please note, some requests regarding your privacy must be made in writing.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Office Manager/Compliance Officer
Telephone: (608) 835-0900 or Fax: (608) 835-3690
Address: 152 Alpine Parkway, Oregon, WI 53575

E-mail: manager@muellergraber.com

ADDENDUM TO NOTICE OF PRIVACY PRACTICES

This addendum to the notice of privacy practices sets forth Wisconsin privacy requirements that are in addition to those in our notice of privacy practices.

Please review it carefully. The privacy of your health information is important to us.

We are required by Wisconsin law to maintain the privacy of your health information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Healthcare operations: Under Wisconsin law, we must have your written permission before we may use and disclose your health information in connection with healthcare operations, unless disclosing to another healthcare provider for treatment or payment purposes adhering to the "minimum necessary standard," or committees and review organizations.

To your family and friends and persons involved in your care: Under Wisconsin law, we must have your written permission before we may disclose your health information, other than limited identifying information, to your family, friends, or other persons involved in your care.

Abuse or Neglect: Under Wisconsin law, we must have your written permission before we may disclose your health information to the appropriate authorities if we believe you are the victim of domestic violence or other crimes. We may report child abuse and the abuse or neglect of vulnerable adult as allowed by Wisconsin law.

PATIENT RIGHTS

Restriction: While we are allowed to determine where we agree to your request to restrict our use and disclosure of your protected health information, Wisconsin law requires that we honor certain restriction requests by private pay patients relating to research or the release of information to government agencies.



152 Alpine Parkway • Oregon, WI 53575 • (608) 835-0900 • Muellergaber.com

Chad T. Mueller, D.D.S.
**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

**** You May Refuse to Sign This Acknowledgment ****

I, _____, have received a copy of this office’s Notice of Privacy Practices.

Name *(Please Print)*: _____

Signature: _____ Date: _____

Office Representative: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other *(Please Specify)*



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Chad T. Mueller, D.D.S.
WISCONSIN CONSENT

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

SECTION A: Individual giving consent

Name: Patient Name (if different from above):

Address: Phone:

TO THE INDIVIDUAL: Please read the following and complete the information requested

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices 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 dental office's Notice of Privacy Practices 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 Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

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 of filled prescriptions, medical/dental supplies, x-rays, and other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION C: Revocation

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at anytime by giving written notice of revocation to the Contact Officer 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 treating you if you revoke this consent.

Office Manager/Compliance Officer Phone: 608-835-0900 Address: 152 Alpine Parkway • Oregon, WI 53575

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.

Signature: Date:

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following.

Personal Representative's/Parent's Name Relationship to Individual

Please forward to your previous dentist:

I authorize the release of my dental records to:

Mueller-Graber Dental

152 Alpine Parkway

Oregon, WI 53575

(608)835-0900

E-mail radiographs to:

info@muellergraber.com

Name (print) _____

Signature: _____