Patient's Full Legal Name _____ **Patient** Birth Date _____

Does Patient have an **ACTIVATED** Power of Attorney (POA) or Legal Guardian (LG)? YES NO

Patient's **Physician** Name _____ Physician's Phone #_____

Physician's Address _____

Name of Patient's preferred **Pharmacy** _____

Does patient's physician advise taking **Antibiotics** before dental appointments ? YES NO

Is patient taking any **Bisphosphonate** drugs (usually taken to treat **Osteoporosis**) ? YES NO

[examples : Alendronate Fosamax Binosto, Risedronate Actonel Atelvia, Ibandronate Boniva, Zoledronic Acid Reclast Zometa Aclasta]

Is patient taking **Blood Thinners** ? YES NO

[examples : Warfarin Coumadin, Dabigatran Pradaxa, Rivaroxaban Xarelto, Apixaban Eliquis, Fondaparinux Arixtra, Heparin Lovenox , Edoxaban Savaysa]

Women : Are you currently pregnant, nursing a newborn child, or actively trying to become pregnant ? YES NO

Has patient ever had an **Allergic Reaction** to any of the following ? (Circle all that apply)

PENICILLIN CEPHALEXIN CLINDAMYCIN AZITHROMYCIN CODEINE OXYCODONE (Percocet)

ACETAMINOPHEN (Tylenol) IBUPROFEN (Advil) NAPROXEN (Aleve) HYDROCODONE (Vicodin - Norco)

Other **Drug Allergies** patient may have :

CIRCLE any of the following conditions patient has had in the past (or) may have at the present :

Prosthetic Heart Valve	COVID-19	Mental Health Disorder
Heart Valve Repair	Donor Organ Recipient	Depression
History of Endocarditis	AIDS	Multiple Sclerosis
Heart Transplant	HIV Positive	Alzheimer's Disease
Congenital Heart Defect	Hepatitis B or C	Parkinson's Disease
Heart Pacemaker	Alcoholism	Neurological Disease
Artificial Joint	Drug Addiction	Kidney Disease

Does patient have any other disease, condition, or medical problem not listed above ? Is there anything else we should know about the patient's health that has not been covered in this form ? YES NO If Yes, explain below, use back if needed :

I certify that the answers given to the questions asked in this **Medical History Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form. I Understand the following : (1) There is an inherent risk of exposure to viruses and bacteria (pathogens) in any setting where people are present. (2) Some of these pathogens can be extremely contagious and if contacted may lead to severe illness and death. (3) By visiting our office, I voluntarily assume all risks related to exposure to bacteria and viruses.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Patient Medication Form (page 2)

Print Only – Ink Only – Circle Correct Answers

Print Patient's Full Name : _____

Is patient taking any Illegal drugs ? YES NO If, yes list drug(s) :

Is patient taking any prescription, OTC (over the counter), or herbal medications ? YES (List Below) NO

Drug or Medication Name	Dosage	Frequency of Use	Reason for Taking Drug or Medication
Example : Atenolol	Example : 100 mg	Example : Twice per day	Example : High Blood Pressure

I certify that the answers given to the questions asked in this **Patient Medication Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Print Only – Ink Only – Circle Correct Answers

Print Patient's Full Name : _____

How did patient hear about our office ? _____

Previous Dentist Name (optional) : _____

How long has it been since patient has seen a dentist ?

How Long has it been since patient last had a dental cleaning ?

Has patient ever been told they have gum disease ? YES NO

Has patient ever had gum surgery ? YES NO If yes, Explain below :

Has patient ever had a complication with dental work ? YES NO If yes, Explain below :

How often does patient brush their teeth ?

How often does patient floss their teeth ?

Does patient smoke or chew tobacco products ? YES NO

Has patient ever had an injury or blow to their mouth ? YES NO If yes, Explain below :

Does patient have any dental problem, disease, or condition not listed above? Is there anything else we should know about patient's dental health that we have not covered in this form? YES NO If Yes, Explain Below :

I certify that the answers given to the questions asked in this **Dental History Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form understand and consent to this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Print Only – Ink Only

Print Patient's Full Name _____

I, the patient/parent/legal guardian/or power of attorney (P/P/LG/POA) hereby authorize Dr. James J. Herget dba James J. Herget DDS LLC and whomever he designates as his dental hygienists and dental assistants to perform dental treatment on the above named patient. I, the (P/P/LG/POA) give my consent to all advisable and necessary dental procedures and x-rays (digital images) needed for diagnostic purposes and dental treatment. I, the (P/P/LG/POA) further consent to the administration of local anesthetics, antibiotics, analgesics, or any other drug that may be deemed necessary by Dr. Herget. I, the (P/P/LG/POA) give consent to Dr. James J. Herget to use at his discretion dental materials he feels is in the best interest of the patient. Should the above named patient or their parent/guardian/POA want a specific dental material placed by Dr. Herget, the request must be made in writing prior to treatment. Dr. Herget reserves the right to refuse treatment if the request for a certain dental material, in his opinion, is not in the best interest of the patient.

Refusing Treatment : Dr. Herget reserves the right to refuse treatment to any patient who themselves or their parent/guardian/POA refuses x-rays (digital images) or any other diagnostic test. **For example :** We will not just perform a cleaning and "skip" diagnostic digital images (x-rays) because a patient's dental insurance only covers x-rays (digital images) once per year. Dr. Herget believes in practicing comprehensive Dentistry and he will not treat patients according to limitations in a patients insurance plan or let insurance companies dictate how a Dentist treats a patient. Dr. Herget respects patient's rights of refusal, but this respect needs to be reciprocal in nature. Patients need to understand Dr. Herget has the right to than refuse treatment. I, the (P/P/LG/POA) understand Dr. James J. Herget has the right to refuse treatment to anyone who refuses x-rays (digital images).

I, the (P/P/LG/POA) understand that there is an element of risk which occurs during any dental procedure and during the administration of any drug or anesthetic. I, the (P/P/LG/POA) have been informed and fully understand in any type of dental procedure there may be unavoidable complications of the treatment. Possible complications may be as follows (this list is not all inclusive) :

1. **General Dentistry :** Soreness, nausea, vomiting, pain, swelling, bruising, restricted opening of the mouth, jaw joint (TMJ) discomfort or stiff jaws, bleeding, adverse drug reactions such as an allergic reaction to anesthetics and post-operative medications, infection, stretching or cracking at the corners of the mouth, etc.
2. **Tooth Extractions :** Delayed healing "Dry Socket", damage to adjacent teeth/fillings/crowns, soft tissue damage, bone splinters/sharp ridges, Portions of tooth remaining : sometimes root tips break and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or the sinus cavity, Sinus infection and/or sinus opening may result with upper back teeth > this may require additional procedures to correct, jaw fracture, loss of additional teeth, general numbness, aspiration or swallowing of fillings, crowns, tooth, or bone fragments etc.
3. **Local Anesthesia :** Swelling/irritation at the injection site(s), damage to tongue and/or lips from patient biting while numb, irritation to veins, arteries, or nerves; Numbness : the lips, chin, teeth, gums, and/or tongue may have a continuous numb feeling; there may also be a loss of taste and/or change is speech; The numbness may remain for a few days, weeks, months, or become permanent etc.

I, the (P/P/LG/POA) also understand recent studies have shown instances of patients taking bisphosphonate drugs (usually taking to treat osteoporosis) such as Fosamax and Boniva, may develop a condition known as osteonecrosis - deterioration of the jaw. I, the (P/P/LG/POA) release Dr. Herget and his staff from all liability should this rare condition occur after receiving routine dental treatment. I, the (P/P/LG/POA) understand and acknowledge any medical or dental procedure has risks and am aware that the practice of dentistry is not an exact science. I, the (P/P/LG/POA) acknowledge that no guarantees have been made concerning the results of treatment and hereby request dental services from Dr. James J. Herget and his employees. I, the (P/P/LG/POA) understand this consent is to be continuing in nature unless revoked in writing by (P/P/LG/POA). I, the (P/P/LG/POA) understand that female patients taking birth control pills need to find an additional method of birth control should Dr. Herget prescribe antibiotics, as the antibiotic may reduce the effectiveness of birth control pills. It is recommended these patients contact their physician regarding this matter. If patient does not comprehend the English language, it is agreed a translator has been used so patient could understand and consent to this form. I, the (P/P/LG/POA) agree Dr. Herget will not be held responsible for any sub-standard treatment or complications from treatment done by another provider such as, but not all inclusive :

Oral Surgeon/Endodontist/Orthodontist/Pedodontist/TMJ specialist/Prosthodontist/Periodontist/Radiologist/Pathologist/General Dentist/Physician/etc.

I certify that the answers given to the questions asked in this **Continuing Consent for Treatment Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this or any other form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Continuing Financial Agreement And Consent Form
Print Only – Ink Only

Print Patient's Full Name _____

If the patient/parent/legal guardian/POA (P/P/L/P) has dental insurance, we will assist the (P/P/L/P) in receiving their maximum allowable benefits as determined by their insurance company. In order to achieve this goal, we need the assistance, cooperation, and understanding from the (P/P/L/P) regarding our payment policy. We will gladly discuss any proposed treatment and answer any questions related to dental insurance.

Our fees are very competitive and range very close to national averages. Not all services are covered benefits by all insurance companies. It is the responsibility of the (P/P/L/P) to keep track of deductibles and yearly maximums. We do **not** keep track of that type of information. All charges are the responsibility of the (P/P/L/P), even if the insurance company pays or approves only a portion of the charges.

If the (P/P/L/P) does not have dental insurance, payment for services are due, in full, at the time the services are rendered. If the (P/P/L/P) does have dental insurance, payment for deductibles and copays are due, in full, at the time of service. We accept cash, money orders, checks, MasterCard, VISA, Discover, CareCredit etc. We will be happy to help process all insurance claims no charge. This financial agreement is to be continuing in nature unless revoked in writing by the (P/P/L/P). We do not offer "in-house" payment plans. For dental financing, see carecredit.com

Refusing Treatment : Dr. Herget reserves the right to refuse treatment to any patient who themselves or their parent/guardian/POA refuses x-rays (digital images) or any other diagnostic test. For example : We will not just perform a cleaning and "skip" diagnostic digital images (x-rays) because a patient's dental insurance only covers x-rays (digital images) once per year. Dr. Herget believes in practicing comprehensive Dentistry and he will not treat patients according to limitations in a patients insurance plan or let insurance companies dictate how a Dentist treats a patient. Dr. Herget respects patient's rights of refusal, but this respect needs to be reciprocal in nature. Patients need to understand Dr. Herget has the right to than refuse treatment. I, the (P/P/L/P) understand Dr. James J. Herget has the right to refuse treatment to anyone who refuses x-rays (digital images).

I, the (P/P/L/P), hereby authorize payment to Dr. James J. Herget of the dental insurance benefits otherwise payable to me. This "Signature on File" is valid from the below date until a written and dated statement of revocation is received by Dr. James J. Herget. I, the (P/P/L/P), authorize Dr. James J. Herget or his employees to provide any insurance company or claim administrator information concerning the dental care of the patient in order to assist in the processing of dental insurance claims.

I, the (P/P/L/P), certify I have read the above information. I, the (P/P/L/P), have had all questions answered regarding this information, and agree to honor and abide by the above stated policy. I, the (P/P/L/P), understand payment is due as services are rendered unless prior arrangements are made. I, the (P/P/L/P), understand any unpaid insurance balances are my responsibility. The undersigned also agrees to be financially responsible for all charges incurred for the above named patient. This agreement is to be continuing in nature unless revoked in writing by the undersigned.

The above named patient and their responsible party such as parent/legal guardian/POA, agree to settle any claim or controversy arising out of or relating to this agreement or services rendered by Dr. James J. Herget and/or his employees by binding arbitration should Dr. James J. Herget request binding arbitration. Should binding arbitration be requested by Dr. James J. Herget, the arbitration shall be conducted in the State of Wisconsin, the arbitrator will be selected by Dr. James J. Herget, and not be consolidated with any claim or controversy of any other party. Also, the (P/P/L/P) understands and agrees Dr. James J. Herget may seek interim or preliminary relief to protect the rights or property of Dr. James J. Herget and/or his employees pending the completion of any arbitration process, if such a process is requested by Dr. Herget. The (P/P/L/P) also understand and agree Dr. James J. Herget also has the right not to use binding arbitration at his discretion.

I certify the information on this form is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE &
E-MAIL/ELECTRONIC COMMUNICATIONS CONSENT
Print Only – Ink Only

Print Patient's Full Name _____

I, the patient/parent/guardian/POA, acknowledge that I have received or downloaded a "Notice of Privacy Practices (NOPP)" from Dr. Herget's website. The NOPP contains a complete description of the uses and disclosures of the patient's health and dental information. I, the patient/parent/guardian/POA, have been given the right to review the "NOPP". I, the patient/parent/guardian/POA, understand Dr. James J. Herget has the right to change the office "NOPP", but I may contact Dr. Herget at any time to obtain a current copy of the office "NOPP".

I, the patient/parent/guardian/POA, understand that, under the Health Insurance Portability & Accounting Act (HIPAA), I have certain rights to privacy regarding my protected dental and health information. I understand that this information can and will be used to : 1. Conduct, plan, direct the patient's treatment, and follow-up among the other healthcare providers who may be involved in the patient's dental treatment, directly and indirectly. 2. Obtain payment from third-party payers such as insurance companies. 3. Conduct normal healthcare operations.

I, the patient/parent/guardian/POA, understand the following under privacy laws : 1. Dr. Herget is required to maintain the privacy of the patient's private health information. 2. Dr. Herget must have the patient/parent/guardian/POA's written permission before he may use and disclose private health information other than for management of his medical records and certain auditing and review activities by staff committees and review organizations. 3. Dr. Herget will not release any information to individuals unless it is in writing from the patient/parent/guardian/POA .

I, the patient/parent/guardian/POA, consent to the use of e-mail communications between myself and the office of Dr. James J. Herget. I, the patient/parent/guardian/POA, understand the only individuals that have access to e-mail accounts are Dr. Herget, Office Manager, Dental Hygienists, Dental Assistants, and Receptionists. All of these individuals have been highly trained in HIPAA regulations and regard electronic communication security as a top priority. The office of Dr. Herget uses the most advanced software to protect patient information. Our computers have daily full hard drive scans and the software definitions are updated multiple times a day. I, the patient/parent/guardian/POA, understand all e-mail or other electronic communications sent from the office to specialists or other healthcare providers are fully encrypted and secure. I, the patient/parent/guardian/POA, understand the office will make every attempt to respond to email communications in a timely manner, but there are times when the office is closed and email messages may not be accessed. The office phone system is not programmed to accept text messages. Our answering machine can be used if needed during hours of office closure to leave voice recordings and messages.

Person to Notify in Case of an Emergency :

Name : _____
Address :
_____
Phone Numbers : _____
Relation to Patient : _____

I certify that the answers given to the questions asked in this form are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

Print Only – Ink Only

1. PATIENT INFORMATION

Patient's Legal First Name _____ Patient's Preferred First Name (Nickname) _____
Patient's Legal Last Name _____
Patient's Legal Middle Name _____
Name of Father (minor patients only) _____
Name of Mother (minor patients only) _____
Patient's Street Address Home)_____
Patient's City, State, Zip (Home) _____
Patient's Phone Numbers (Land Line) _____(Work #) _____
(Cell Number)_____(Other #) : _____
Patient's E-mail Address _____
Patient's Social Security Number (**REQUIRED***) _____
Patient's Sex (circle) : MALE FEMALE
Patient's Marital Status (circle) : SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED
Patient's Birth Date _____
Patient's Employer _____
Patient's Employer Street Address _____
Patient's Employer City, State, Zip _____
Patient's Occupation _____

2. RESPONSIBLE PARTY INFORMATION - This is the person responsible for payment of this account and/or is the policy holder for the above named patient's dental insurance.

Fill out this area if the responsible party is **DIFFERENT** than the patient information above.
This area is used to obtain Parent/Spouse/Court Appointed Legal Guardian/Power of Attorney information etc.

Responsible Party's Legal First Name _____
Responsible Party's Legal Last Name _____
Responsible Party's Legal Middle Name _____
Responsible Party's Street Address (Home) _____
Responsible Party's City, State, Zip (Home) _____
Responsible Party's Phone Numbers (Land Line) _____(Work #) _____
(Cell Number)_____(Other #) : _____
Responsible Party's E-mail Address _____
Responsible Party's Social Security Number (**REQUIRED***) : _____
Responsible Party's Sex (circle) : MALE FEMALE
Responsible Party's Marital Status (circle): SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED
Responsible Party's Birth Date _____
Responsible Party's Employer _____
Responsible Party's Employer Street Address _____
Responsible Party's Employer City, State, Zip _____
Responsible Party's Occupation _____

3. CERTIFICATION

I certify that the answers given to the questions asked in this **Patient Registration Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____

* SS numbers are required by our office for multiple reasons. First, this number is a required field in our dental practice software program. This is the only number that uniquely identifies each individual and without it the software will give us an error message and not allow us to enter a new patient. Second, this number is often needed to communicate between insurance companies and needed to submit claims. Our office uses full encryption software to protect your private information !

Dental Insurance Information Form

Print Only – Ink Only – Circle Correct Answers

Print Patient's Full Name : _____

Primary Insurance Coverage :

Insurance Company _____
Group Number _____
Insured ID Number _____
Full Name of Insured _____
Patient's Relation to the Insured (circle) SELF SPOUSE CHILD OTHER
Is insurance plan purchased/provided through an employer ? (circle) YES NO
If YES, Name of Insured's Employer _____
If NO, We will assume this plan was purchased individually as a "self-insured" plan
Insured's Home Phone _____ Insured's Cell Number _____
Insured's Work Phone_____ Insured's Other Number _____
Home Address of the Insured :

Birth Date of the Insured _____
Sex of the Insured (circle) MALE FEMALE
Marital Status of the Insured (circle) SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED

Secondary Insurance Coverage :

Insurance Company _____
Group Number _____
Insured ID Number _____
Full Name of Insured _____
Patient's Relation to the Insured (circle) SELF SPOUSE CHILD OTHER
Is insurance plan purchased/provided through an employer ? (circle) YES NO
If YES, Name of Insured's Employer _____
If NO, We will assume this plan was purchased individually as a "self-insured" plan
Insured's Home Phone _____ Insured's Cell Number _____
Insured's Work Phone _____ Insured's Other Number _____
Home Address of the Insured

Birth Date of the Insured _____
Sex of the Insured (circle) MALE FEMALE
Marital Status of the Insured (circle) SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED

I certify that the answers given to the questions asked in this **Dental Insurance Information Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable)_____

Power of Attorney/Legal Guardian Signature (if applicable)_____ Date _____