NEW PATIENT FORMS

FAMILY DENTISTRY™
DR. MICHAEL OTTO & DR. KRISTIN KOTECKI

3223 4th Street SW
Mason City, Iowa 50401
641.424.6461

24 South Hawkeye
Nora Springs, Iowa 50458
641.749.5430

ADULT PATIENT INFORMATION

Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 recieve. Thank you for answering the following questions.

PATIENT INFORMATION *Answers to all Questions are for Office Use and Strictly Confidential*

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Sex: M F Birthdate ___/___/___ SS Number _____ Marital Status: S M W D

Email Address _____ Can We Contact You With This Address: Yes No

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Previous General Dentist (Name, Address & Phone Number) _____

How Did You Hear About Our Office ☐ Friends / Co-Worker ☐ Family ☐ Website / Internet ☐ Phone Book ☐ Location ☐ Other _____

Emergency Contact Name _____ Relation To You _____ Phone _____

SPOUSE'S INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Sex: M F Birthdate ___/___/___ SS Number _____

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

INSURANCE INFORMATION

Primary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ___/___/___

Insurance ID Number _____ Subscriber _____ Group Number _____

Secondary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ___/___/___

Insurance ID Number _____ Subscriber _____ Group Number _____

MEDICAL HISTORY

1. Are You Under A Physicians Care Now?	Yes	No	If Yes, Explain _____
2. Have You Ever Been Hospitalized or Had A Major Operation?	Yes	No	If Yes, Explain _____
3. Have You Ever Had A Serious Head or Neck Injury?	Yes	No	If Yes, Explain _____
4. Are You Taking Any Medications, Drugs or Supplements?	Yes	No	If Yes, List _____
5. Do You Take, or Have You Taken, Phen-fen or Redux?	Yes	No	If Yes, Explain _____
6. Have You Ever Taken Any Medication Containing Bisphosphonates?	Yes	No	If Yes, List _____
7. Are You On A Special Diet?	Yes	No	If Yes, Explain _____
8. Do You Use Tobacco or Vape?	Yes	No	If Yes, Explain _____
9. Do You Use Controlled Substances?	Yes	No	If Yes, Explain _____

10. Are You Allergic To Any Of The Following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other If Other Please List: _____

MEDICAL HISTORY *(Continued From Previous Page)*

If You Are A Woman ☐ Are You Pregnant or Trying To Get Pregnant ☐ Are You Nursing ☐ Are You Taking Oral Contraceptives

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

☐ AIDS / HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis / Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores / Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells / Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack / Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain In Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Snoring / Sleep Apnea
☐ Spina Bifida
☐ Stomach / Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have You Ever Had A Serious Illness Not Listed? Yes No If Yes, List _____

Do You Currently Use A CPAP Machine? Yes No How Often _____

DENTAL HISTORY

1. Do You Have A Specific Dental Problem? Yes No If Yes, Explain _____
2. Do You Have Dental Examinations On A Routine Basis? Yes No How Often _____
3. Would You Describe Your Present Dental Health As Good? Yes No Comments _____
4. Do You Feel Nervous About Having Dental Treatment? Yes No If Yes, Explain _____
5. Have You Ever Had A Bad Experience In A Dental Office? Yes No If Yes, Explain _____
6. Do You Want To Keep Your Remaining Teeth? Yes No If No, Explain _____
7. Do You Like Your Smile? Yes No If No, Explain _____
8. Have You Had A Reaction To Dental Anesthetic? Yes No If Yes, Explain _____
9. Do You Need To Be Pre-Medicated For Dental Treatment? Yes No If Yes, Explain _____
10. Is There Anything You Would Like To Bring To Our Attention? Yes No If Yes, Explain _____
11. Do You Wish To Talk To The Doctor Privately? Yes No
12. How Often Do You Brush? _____ Floss? _____ Use Mouthwash? _____
13. What Has Been Used For Comfort In Previous Dental Treatment? ☐ Local Anesthetic ☐ N_2O Gas ☐ Neither

MARK AN X IN THE BOX IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

☐ Active Decay
☐ Bleeding Gums
☐ Gum Disease
☐ Orthodontic Treatment
☐ Tooth Straightening
☐ Root Canal Treatment
☐ Dental Implants
☐ Removable Dental Appliances
☐ Dentures
☐ Hot / Cold Tooth Sensitivity
☐ Sensitive To Sweets
☐ Sensitive When Chewing
☐ Bruxing or Grinding Teeth
☐ Clicking or Popping In Jaw
☐ Discomfort In Jaw Joint (TMJ)
☐ Food Wedging Between Teeth

Have You Ever Had Any Other Dental Procedures Not Listed? Yes No If Yes, Explain _____

Please List Any Questions, Comments or Additional Information Which May Assist Us In Providing For Your Care _____

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.

X _____ Date _____

Patient Signature (Parent or Guardian)

CHILD PATIENT PEDODONTIC HISTORY

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641.749.5430

Date _____

PATIENT INFORMATION *Answers to all Questions are for Office Use and Strictly Confidential*

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Sex: M F Birthdate ___/___/___ SS Number _____

Previous General Dentist (Name, Address & Phone Number) _____

_____

Reason For Changing Dentist _____

PARENTS INFORMATION

Fathers Name _____ SS Number _____ Birthdate ___/___/___

Cell Phone _____ Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Mothers Name _____ SS Number _____ Birthdate ___/___/___

Cell Phone _____ Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Nearest Friend or Relative (Name & Phone Number) _____

How Did You Here About Our Office ☐ Friends ☐ Family ☐ Website ☐ Phone Book ☐ Location ☐ Other _____

INSURANCE INFORMATION

Who Is Responsible For Account _____

Dental Insurance Company _____ Subscriber _____

Insurance ID Number _____ Group Number _____

MEDICAL HISTORY

1. Medical Doctor (Name, Address & Phone Number) _____

2. Is Your Child In Good Health?	Yes	No	Explain: _____
3. Has He / She Had A Physical Exam In The Last Year?	Yes	No	Date: _____
4. Is Your Child Now Under Medical Care?	Yes	No	Why: _____
5. Has He / She Ever Been Hospitalized or Had A Major Operation?	Yes	No	Explain: _____
6. Has He / She Ever Had A Serious Head or Neck Injury?	Yes	No	Explain: _____
7. Is He / She Taking Any Medications, Supplements or Drugs?	Yes	No	What: _____
8. Is He / She Allergic To Any Medications or Substances?	Yes	No	What: _____
9. Is The Patient Pregnant? (Adolescent Woman)	Yes	No	Due Date: _____

MARK AN X IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING

☐ Aids / HIV	☐ Cancer	☐ Excessive Thirst	☐ Hemophilia	☐ Lung Disease	☐ Sinus Trouble
☐ Allergies	☐ Cerebral Palsy	☐ Fainting Of Dizziness	☐ Hepatitis A (Infect.)	☐ Mental Retardation	☐ Snoring / Sleep Apnea
☐ Anemia	☐ Chemotherapy / Radiation	☐ Fever Blisters	☐ Hepatitis B (Serum)	☐ Nervousness	☐ Thyroid Disease
☐ Arthritis / Gout	☐ Cold Sores	☐ Frequent Cough	☐ Herpes	☐ Pain In Jaw Joints	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Congenital Heart Lesion	☐ Hay Fever	☐ High Blood Pressure	☐ Psychiatric Care	☐ Ulcers
☐ Asthma	☐ Cortisone Medicine	☐ Hearing Disability	☐ Hives or Skin Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Blood Disease	☐ Diabetes	☐ Heart Murmur	☐ Hypoglycemia	☐ Rheumatism	☐ X-ray Or Cobalt Tmt.
☐ Blood Transfusion	☐ Drug Addiction	☐ Heart Surgery	☐ Kidney Trouble	☐ Scarlet Fever	☐ Yellow Jaundice
☐ Bruise Easily	☐ Epilepsy Or Seizures	☐ Heart Trouble	☐ Liver Disease	☐ Sickle Cell Anemia	

CONTINUED FROM PREVIOUS QUESTION

10. Have You Ever Had Any Other Serious Illness Or Condition Not Marked? Describe In Detail: _____ Yes No

_____

DENTAL HISTORY

1. Does Your Child Have A Specific Dental Problem? Describe: _____ Yes No

_____

2. Does Your Child Have Dental Examinations On A Routine Basis? Date of Last Visit: _____ Yes No

Last X-Rays: _____ Last Fluoride Tx: _____ Last Cleaning: _____

3. Would You Describe Their Present Dental Health As Good? Comments: _____ Yes No

_____

4. Has He / She Been Treated For Any Gum Diseases (Gingivitis, Periodontitis, Trench Mouth, Pyorrhea)? _____ Yes No

5. How Often Does He / She Brush? _____ Floss? _____ Use Mouth Rinses? _____ Yes No

6. Does He / She Feel Nervous About Having Dental Treatment? _____ Yes No

7. Has He / She Ever Had A Bad Experience In A Dental Office? Describe: _____

_____

8. Does He / She Ever Brux Or Grind Your Teeth? Discuss: _____ Yes No

9. Has He / She Ever Had Orthodontic Treatment (Tooth Straightening)? _____ Yes No

10. Does He / She Ever Have Clicking, Popping Or Discomfort In The Jaw Joints (TMJ)? _____ Yes No

Please Discuss: _____

11. Has He / She Had A Root Canal Or Pulpotomy Treatment? _____ Yes No

12. Has He / She Ever Lost A Tooth Due To An Accident Or Decay? _____ Yes No

13. Has He / She Often Had Toothaches? _____ Yes No

14. Has He / She Had Frequent Sores In His / Her Mouth? _____ Yes No

15. Has He / She Had Any Injuries To His / Her Mouth Or Jaw? _____ Yes No

16. Has He / She Ever Had A Thumb Sucking Habit Or Used A Pacifier? _____ Yes No

17. Does He / She Use Tobacco? What Type? _____ Yes No

18. Does He / She Frequently Snack On Sweets, Chew Gum Or Drink Pop? _____ Yes No

19. What Has Been Used For Comfort In Previous Dental Treatment? ☐ Local Anesthetic ☐ N_2O Gas ☐ Neither Yes No

20. Has He / She Had A Reaction To Dental Anesthetic? _____ Yes No

21. Has He / She Been Told They Need To Be Pre-Medicated For Dental Treatment? _____

22. Does He / She Have Any Other Comments Or Concerns That You Would Like To Bring To Our Attention? _____ Yes No

_____

23. Do You Wish To Talk To The Doctor Privately About Any Problem? _____ Yes No

X _____ Date _____

Patient Signature (Parent or Guardian)

Reviewed by: Doctor _____ Date _____

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INFORMATION UPDATE

Date _____

PATIENT INFORMATION

Answers to all Questions are for Office Use and Strictly Confidential

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Sex: M F Birthdate ___/___/___ SS Number _____ Marital Status: S M W D

Email Address _____ Can We Contact You With This Address: Yes No

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Person Responsible for Account _____

Emergency Contact Name _____ Relationship To You _____ Phone _____

SPOUSE'S INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Sex: M F Birthdate ___/___/___ SS Number _____ Email _____

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

PAYMENT INFORMATION

Primary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ___/___/___

Insurance ID Number _____ Subscriber _____ Group Number _____

Secondary Dental Insurance Company _____ Address _____

Insured's Name _____ Birthdate ___/___/___

Insurance ID Number _____ Subscriber _____ Group Number _____

Other (Please Check One) ☐ Cash ☐ Check ☐ Credit ☐ Care Credit

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental service upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date _____ Relationship to Patient _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render service on the assumption that charges will be paid by any insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me undermy policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect mydebt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signature _____ Date _____

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HIPAA NOTICE OF PRIVACY PRACTICES

Date _____

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. This Notice describes the privacy practices of Dr. Otto & Dr. Kotecki Family Dentistry ("Dental Practice"). "We" and "Our" means the Dental Practice. "You" and "Your" means our patient. If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice:	Dr. Otto & Dr. Kotecki Family Dentistry
Privacy Official:	Jeralyn Huisman
Mailing Address:	3223 4th Street SW
	Mason City, Iowa 50401
Phone Number:	641-424-6461

INFORMATION COVERED BY THIS NOTICE

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- Maintain the privacy of your health information
- Give you this Notice of our legal duties and privacy practices with respect to that information
- Abide by the terms of our Notice that is currently in effect

OUR USE AND DISCLOSE OF YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, email or text.

Treatment Alternatives and Health-Related Benefits and Services We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object, if you are not present, or we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you

Disclosures Required by Law We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Lawsuits and Legal Actions We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Public Health Activities We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Law Enforcement Purposes We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

YOUR WRITTEN AUTHORIZATION FOR ANY OTHER USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

We Have the Right to Change Our Privacy Practices and This Notice We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice. You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.9/13

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3223 4th Street SW
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ACKNOWLEDGMENT OF RECEIPT - HIPPA NOTICE OF PRIVACY PRACTICES

Please Note: It is your right to refuse to sign this Acknowledgment.

I acknowledge that I have received a copy of Dr. Otto & Dr. Kotecki Family Dentistry's HIPAA Notice of Privacy Practices.

First Name:_____ Middle Initial: _____
(Please print) (Optional)

Last Name:_____
(Please print)

Signature: _____ Date: ___/___/___

OR IF PATIENT IS UNDER THE AGE OF 18

Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient (Check One): ☐ Parent ☐ Guardian ☐ Power of Attorney

Other: _____

Dental Office Use Only

I have tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because of:

_____ An emergency prevented us from obtaining acknowledgment.

_____ A communication barrier prevented us from obtaining acknowledgment.

_____ The individual was unwilling to sign.

_____ Other: _____

Staff Member Signature:_____ Date:_____

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FINANCIAL POLICY AGREEMENT

THE FOLLOWING FINANCIAL ARRANGEMENTS ARE AVAILABLE. PLEASE INDICATE YOUR CHOICE OF PAYMENT

It is our belief that all patients are concerned not only about the treatment that is required, but also how they may handle their account. In order to eliminate misunderstandings, we feel definite financial arrangements should be agreed upon prior to treatment. Therefore, our purpose is to acquaint you with our financial policies and to give you an estimate for all necessary work required at this time and in the future.

OPTION A: Payment In Full At Time Of Service

☐ **Cash / Check Savings Plan:** We offer a 5%* cash savings with payment the day of services.

☐ **Credit Cards:** For your convenience, we accept Mastercard, Visa, and Discover. Due to the bank handling charge, we offer a 3%* savings with payment the day of services.

**Note: Savings only valid for fees not covered by insurance.*

OPTION B: Coverage By Dental Insurance

☐ Estimated portion is due at time of service. If the insurance company fails to make payment within 60 days, you are responsible for the full amount owed Dr. Otto & Dr. Kotecki. It is important for you to be informed that our professional services are rendered and charged to YOU. Therefore, you are directly responsible to us for the cost of your treatment. Dental insurance pays only a portion of your investment. Typical criteria and terms espoused by insurance carriers include:

"Reasonable And Customary Fees" "Yearly Maximum" "Pre-Authorization"

Each of these criteria and terms varies by plan and insurance carrier. To ensure you receive maximum benefits: we recommend that you read your insurance booklet and become familiar with your specific plan requirements. Low reimbursement may be the result of coverage purchased for the insurance plan. Your employer, the purchaser of the insurance plan, selects the range of benefits. If you feel the dental benefits are inadequate, discuss this matter with your employer so the alternatives can be investigated.

OPTION C: Payment Plans / Financing

☐ Patients wishing to finance treatment fees may be eligible for payment plans / financing through Care Credit. Interest free options of 3, 6, 12 and 18 months may be available. Please ask the receptionist or office manager for details. In order to comply with the Truth-In-Lending Law, if you wish to make monthly payments on your account, a written agreement must be signed by the responsible party.

OPTION D: Dr. Otto & Dr. Kotecki Membership Club

☐ Club Participant

☐ I would be interested in more information about In-house Membership Club.
(Please ask our business team to explain this wonderful program)

PLEASE NOTE: CROWN, BRIDGE, AND DENTURE SERVICES

All services will be charged out on the first appointment. Please keep in mind if you wish to take advantage of the 5% savings. Because of lab fees, we request one-third of the payment down on the first operative visit.

PLEASE NOTE: LATE CHARGE POLICY

A monthly finance charge of 1.5 % is imposed on all accounts over 60 days (18% annually). If 60 days have passed since your last payment, your account may be considered for small claims court.

Signature Of Responsible Party _____ Date _____

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SHARED DECISION MAKING TOOL FOR ARTIFICIAL JOINT PROPHYLAXIS

A shared decision making tool promotes the collaborative decision making between patient and clinician for the best treatment strategy.
It is an additional tool to be used and supplements, but does not replace, informed consent procedures.

SHOULD I TAKE ANTIBIOTICS BEFORE MY DENTAL PROCEDURE?

You have an orthopaedic implant *(Joint Replacement, Metal Plates or Rods, etc.)* from a previous orthopaedic surgery.

- A potential complication of these implants is bacterial infection, which occurs in approximately 1-3 percent of patients. These infections require more surgery as well as antibiotic usage for an extended period of time. Most infections occur around the time of the procedure (within one year), but some have occurred much later.
- In theory, late implant infections are caused by the spread of the bacteria from the bloodstream to the implant. Unfortunately, there is no clear scientific evidence to support this theory. We know that many patients with orthopaedic implants frequently have bacteria in their blood that does not spread to their implants.

Dental procedures have long been considered a potential cause of implant infections even after the initial orthopaedic postoperative period. This is because dental procedures can introduce bacteria from the mouth into the bloodstream. However, this fact should be considered in the context that eating and performing oral hygiene at home may also introduce oral bacteria into the blood.

- Traditionally, antibiotics have been provided prior to dental procedures in patients with orthopaedic implants to minimize the bacteria that get into the blood.
- Best evidence, however, does not show that antibiotics provided before oral care help prevent infections of orthopaedic implants.
- The routine use of antibiotics in this manner has potential side effects such as increased bacterial resistance, allergic reactions, diarrhea and may even cause death.

Patients who have compromised immune systems might be at greater risk for implant infections.

- Diabetes, rheumatoid arthritis, cancer, chemotherapy and chronic steroid use are examples suggesting immunosuppression. Please discuss your potential for immunosuppression with your physician or dentist.
- Patients who are immune-compromised might wish to consider antibiotics before dental procedures because of their greater risk for infection.
- Decisions with regard to antibiotic premedication should be made by patients, dentists and physicians in a context of open communication and informed consent.

1. PATIENTS WITH ORTHOPAEDIC IMPLANTS HAVE THE FOLLOWING
a. 0 percent chance of infection
b. 0-1 percent chance of infection
c. 1-3 percent chance of infection
d. >3 percent chance of infection

2. MOST IMPLANT INFECTIONS
a. are related to dental procedures
b. occur around the time of surgery
c. are related to skin infections
d. occur long after surgery

3. SOME DENTAL PROCEDURES
a. routinely cause implant infections
b. are the primary source of implant infections
c. never cause implant infections
d. allow bacteria to enter the bloodstream

4. ROUTINE PRE-DENTAL PROCEDURE ANTIBIOTICS
a. are not supported by current evidence
b. may be beneficial in certain groups of patients
c. are associated with other unwanted side effects
d. all of the above

PATIENT CHECKLIST

1. I Have Adequate Understanding Of Implant Infections Associated With Dental Procedures _____ Yes No
2. My Physician/dentist Has Discussed My Specific Risk Factors With Me _____ Yes No
3. I Need Further Education And Discussion On This Issue _____ Yes No
4. I Am Immunocompromised Because I Have: (Specify Condition) _____

BASED ON THIS EDUCATIONAL MATERIAL AND DISCUSSION, I WILL:

a. _____ Not take antibiotics before my dental procedures.

b. _____ Take antibiotics before my dental procedures.

_____ Date _____

Patient Printed Name Patient Signature (Parent or Guardian)

Reviewed by: Doctor _____ Date _____

FAMILY DENTISTRY™
DR. MICHAEL OTTO & DR. KRISTIN KOTECKI

3223 4th Street SW
Mason City, Iowa 50401
641.424.6461

24 South Hawkeye
Nora Springs, Iowa 50458
641.749.5430

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in contrast to feeling just tired in the following situations? This scale refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to speculate how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

USE THE FOLLOWING TO RATE YOUR CHANCE OF DOZING

SCORE	CHANCE OF DOZING
0	No Chance of Dozing
1	Slight Chance of Dozing
2	Moderate Chance of Dozing
3	High Chance of Dozing

SCORE YOUR ANSWERS FOR EACH QUESTION

SITUATION	CHANCE OF DOZING
Sitting And Reading	
Watching TV	
Sitting Inactive In A Public Place *(e.g. A Theater or A Meeting)*	
Riding As A Passenger In A Car For An Hour Without A Break	
Lying Down To Rest In The Afternoon When Circumstances Permit	
Sitting And Talking To Someone	
Sitting Quietly After A Lunch Without Alcohol	
Riding In A Car, While Stopped For A Few Minutes In Traffic	

YOUR TOTAL POINTS FROM THE ABOVE QUESTIONS: _____ EVALUATE YOUR FINAL SCORE AGAINST THE TABLE BELOW:

SCORE	RESULT
1 - 6	Congratulations, You Are Getting Enough Sleep!
7 - 8	Your Score Is Average
9 and Up	Seek The Advice of A Sleep Specialist Without Delay

PATIENT AUTHORIZATION

_____ Date _____

Patient Printed Name

Patient Signature (Parent or Guardian)

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SLEEP SCREENING EVALUATION

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

First Name _____ Middle Name _____ Last Name _____

Do You Currently Use A CPAP Machine? ☐ Yes ☐ No If Yes, How Often _____

⚠ *If you answered yes, please skip the rest of the form, and sign your name at the bottom.*

Weight _____ *(in lbs.)* **Age** _____ *(in years)* **Date of Birth** ____ / ____ / ____ *(month) (day) (year)* **Gender:** ☐ Male ☐ Female

Height _____ *(in inches)* / _____ *(BMI)* **Neck Size** _____ *(in inches)*

TALLY ALL RISK POINTS
(For Office Use Only)

Neck Size
+2 Male > 16.5
+2 Female > 15.0

Score _____

COMPLETELY FILL IN BOX FOR EACH QUESTION - ANSWER ALL QUESTIONS

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

High Blood Pressure	☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	**Depression**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Sleep Apnea**	☐ Yes	☐ No

Co-Morbidities
+1 For Each "Yes"

Score _____

Lung Disease	☐ Yes	☐ No	**Nasal Oxygen Use**	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No	**Restless Leg Syndrome**	☐ Yes	☐ No
Narcolepsy	☐ Yes	☐ No	**Morning Headaches**	☐ Yes	☐ No
Sleeping Medications	☐ Yes	☐ No	**Pain Medications** *(e.g. Vicodin, Oxycontin, etc.)*	☐ Yes	☐ No

Do Not Assign Any Points For These Eight Responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. *(M.W. Johns, Sleep 1991)*

0= Would Never Doze | 1= Slight Chance of Dozing | 2= Moderate Chance of Dozing | 3= High Chance of Dozing	0	1	2	3
Sitting And Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, Inactive, In A Public Place (Theater, Meeting, etc.)	☐	☐	☐	☐
As A Passenger In A Car For An Hour Without A Break	☐	☐	☐	☐
Lying Down To Rest In The Afternoon When Circumstances Permit	☐	☐	☐	☐
Sitting And Talking To Someone	☐	☐	☐	☐
Sitting Quietly After Lunch Without Alcohol	☐	☐	☐	☐
In A Car, While Stopped For A Few Minutes In Traffic	☐	☐	☐	☐

Epworth Score **Total**:
The Values From All 8 Questions. If "11" or Less **Score = 0**
If "12" or More **Score = 2**

Score _____

Frequency	0-1 Times/Week	1-2 Times/Week	3-4 Times/Week	5-7 Times/Week
On Average In The Past Month, How Often Have You Snored or Been Told That You Snored?	☐ Never	☐ Rarely (+1)	☐ Sometimes (+2)	☐ Frequently (+3)	☐ Almost Always (+4)
Do You Wake Up Choking or Gasping?	☐ Never	☐ Rarely (+1)	☐ Sometimes (+2)	☐ Frequently (+3)	☐ Almost Always (+4)
Have You Been Told You Stop Breathing In Your Sleep or Wake Up Choking or Gasping?	☐ Never	☐ Rarely (+1)	☐ Sometimes (+2)	☐ Frequently (+3)	☐ Almost Always (+4)
Do You Have Problems Keeping Your Legs Still At Night or Need To Move Them To Feel Comfortable?	☐ Never	☐ Rarely (+1)	☐ Sometimes (+2)	☐ Frequently (+3)	☐ Almost Always (+4)

Assign Points For Each Of The First Three Responses

Score _____ Score _____ Score _____ Score _____

Sign Here Patient Signature *(Parent or Guardian)* _____ Date _____

FOR OFFICE USE ONLY
After Screening and evaluation of above named patient, i find there is a strong probability for a sleep related breathing disorder. I will refer patient back to their primary care physician or a sleep specialist for further evaluation.

If Point Totals = 4 or 5 (Low Risk)
6 or 10 (High Risk) and 11 or More
(Very High Risk)

TOTAL SCORE:

Dentist Signature _____ Date _____