



Date: _____

Patient Name:

(Last) (First) (Mi)

Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: Home: _____ Business: _____ Cell: _____

Email Address: _____

Employer Name: _____

Emergency Contact: _____ Phone Number: _____

Name Of Person Referred By: _____

Billing Instruction 2

Name of person to be billed: _____ Relationship: _____

Address (if different): _____

Telephone: Home: _____ Business: _____ Cell: _____

Dental Insurance Company: _____

Subscriber ID: _____ Date of Birth: _____

Insurance Group Number: _____

Employer: _____

Are you covered by a second dental plan? Yes / No

If yes, Second Dental Insurance Company: _____

Subscriber ID: _____ Date of Birth: _____

Insurance Group Number: _____

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. All accounts are subject to a finance charge computed on the unpaid balance 90 days and over. Maximum periodic rate and annual percentage rate are determined by the laws of the patient's state of residence. In the event a finance charge may be made on your account, the periodic rate is 1.5% and the annual percentage rate is 18%.

Patient Signature: _____

(If patient is a minor, parent or guardian signature, please)

Please list any disease, condition, or problem you have that is not listed on the other side.

Please list any hospitalizations or surgeries you have had.

Please list all medications you are taking. (Including vitamins and supplements)

	YES	NO
Have you been diagnosed with sleep apnea?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes: do you wear a CPAP?.....	<input type="checkbox"/>	<input type="checkbox"/>
A sleep appliance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed or been told of any of the following while you are sleeping?		
Snoring, heavy or loud breathing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Break or pause in breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Gasp, choke, or struggle to breathe?	<input type="checkbox"/>	<input type="checkbox"/>
Restless or agitated sleep? Grinding teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal head posture (hyper-extension, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any of the following during the day?		
Difficulty waking?	<input type="checkbox"/>	<input type="checkbox"/>
Wake with headaches and/or sore teeth/jaw muscles?.....	<input type="checkbox"/>	<input type="checkbox"/>
Tired during day?	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to cold?	<input type="checkbox"/>	<input type="checkbox"/>
Gum tissue recession?	<input type="checkbox"/>	<input type="checkbox"/>

Women Only:

Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you using a birth control method?	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History



G² Dental
family dentistry

Patient's Name: _____

Date of Birth: _____

Reason for this visit: _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (name and location): _____

Have you had a complete series of dental films (x-rays) Taken? Yes No When? _____

Where? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking water fluoridated? _____

Is it important for you to keep your teeth? **YES** **NO**

Is it important to better the function of your teeth? . . .

Does food frequently get caught between teeth?

Do your gums often bleed while brushing?

Have you noticed loosening of your teeth?

Have you injured your head, neck, or jaw?

Do you have difficulty eating or swallowing?

Do you have a dry mouth?

Have you had a change in your ability to taste foods? . .

Problems of the Jaw – Have you noticed:

Clicking of the jaw?

Pain (Joint, ear, side of face)?

Difficulty opening or closing?

Difficulty chewing?

Oral habits: Do you:

Clench or grind your teeth?

Bite your lips or cheek frequently?

Have you had: **YES** **NO**

Orthodontic treatment (braces)?

Oral surgery?

Gum treatment

Your bite adjusted?

A bite plane/guard or other appliance?

Have you ever had any difficult extractions in the past?

Have you ever had any prolonged bleeding following extractions?

Do you wear dentures or partials?
If yes, date of placement _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

If you could change anything about your smile, what would you change? _____

If you had to rate your smile from 1-10 with 1 being the worst & 10 being best, what would you give yourself? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X

Signature of patient or parent if minor

Date

Doctor's Signature

Date

Pediatric Airway Questionnaire

	YES	NO
1. Does your child have trouble going to bed or falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>
2. Awaken during the night and have trouble returning to sleep?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does he/she tend to breathe through their mouth during the day or during sleep?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have dry mouth or bad breath upon waking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you noticed or been told of any of the following while your child is sleeping?		
a. Snoring, heavy or loud breathing?	<input type="checkbox"/>	<input type="checkbox"/>
b. Break or pause in breathing?	<input type="checkbox"/>	<input type="checkbox"/>
c. Gasp, choke, or struggle to breathe?	<input type="checkbox"/>	<input type="checkbox"/>
d. Restless or agitated sleep? Grinding teeth?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abnormal head posture (hyper-extension, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Excessive sweating?	<input type="checkbox"/>	<input type="checkbox"/>
g. Wetting the bed?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you noticed any of the following during the day?		
a. Difficulty waking?	<input type="checkbox"/>	<input type="checkbox"/>
b. Wakes with headaches?	<input type="checkbox"/>	<input type="checkbox"/>
c. Groggy, tired or “out of it”?	<input type="checkbox"/>	<input type="checkbox"/>
d. Hyperactive?	<input type="checkbox"/>	<input type="checkbox"/>
e. Teachers commented?	<input type="checkbox"/>	<input type="checkbox"/>
7. Child often:		
a. Does not seem to listen when spoken to directly?	<input type="checkbox"/>	<input type="checkbox"/>
b. Has difficulty organizing tasks?	<input type="checkbox"/>	<input type="checkbox"/>
c. Easily distracted by extraneous stimuli?	<input type="checkbox"/>	<input type="checkbox"/>
d. Fidgets with hands or feet or squirms in seat?	<input type="checkbox"/>	<input type="checkbox"/>
e. Interrupts or intrudes on others?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is your child frequently sick, have a history of sore throat, ear infections, sinus infections, or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
9. Stop growing at a normal rate at any time since birth? Overweight?	<input type="checkbox"/>	<input type="checkbox"/>
10. Habits such as: pacifier / thumb sucking / lip biting / other?	<input type="checkbox"/>	<input type="checkbox"/>

G2 Dental NOTICE OF PRIVACY PRACTICES

Effective Date of This Notice: Feb 16, 2026

G2 Dental Address: 1017 Centennial Drive SW, Forest Lake, MN 55025
Phone: (651) 464-2248; **Fax:** (651) 464-9050; **Web site:** www.g2dental.com
Privacy Officer: Chad Wynia

Notice of Privacy Practices: Your Information. Your Rights. Our Responsibilities.

This notice describes how your health information may be used and disclosed by G2 Dental and how you can get access to this information. *Please review it carefully.*

YOUR RIGHTS: You have certain rights pertaining to your health information. Your rights and some of our responsibilities are:

- 1. Obtain an electronic or paper copy of your health record:** You can ask to see or request an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this. Upon written request, we will provide a copy or summary of your health information within a reasonable time.
 - If you ask to see or receive a copy of your record for purposes of reviewing current health care, we may not charge you a fee.
 - If you request copies of your patient records of past health care, or for certain appeals, we may charge you specified fees.
- 2. Request your health record be amended or corrected:**
 - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- 3. Request us to contact you confidentially:**
 - You can ask us to contact you in a specific way, for example, by home or office phone or by sending mail to a different address.
 - We will say "yes" to all reasonable requests.
- 4. Request us to limit what we use or share:**
 - You can ask us not to use or share certain health information for treatment, payment, or our operations (TPO). We are not required to agree to your request, and we may say "no" if it would affect your care. Such requests should be made in writing.
 - If you pay for a service or health/health care item out-of-pocket in full, you can ask us not to share that information, for the purpose of payment or our operations, with your health/health insurer. We will say "yes" unless a law requires us to share that information.
- 5. Get a list of those with whom we've shared information:**
 - You can ask for a list (an accounting) of the times we've shared your health information during the previous six years from the date you ask, including who we shared it with and why. Such requests should be made in writing.
 - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures such as any you asked us to make. We will provide one list/accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- 6. Get a copy of this privacy notice:**
 - You can ask for a paper copy of this notice at any time and we will do so promptly, even if you agreed to receive it electronically.
- 7. File a complaint if you feel your rights are violated:**
 - You can complain if you feel we have violated your rights by contacting our Privacy Officer using the contact information at the top of this page. ***We will not retaliate against you for filing a complaint.***
 - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S. W., Washington, DC 20201, or calling 1-877-696-6775, or visiting the following website: www.hhs.gov/ocr/privacy/hipaa/complaints/.

YOUR CHOICES

- 1. For certain health information, you can tell us your choices about what we share:**
 - If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your written instructions. In these cases, you have both the right and choice to tell us NOT to:
 - a. *Share information with your family, close friends, or others involved in your care, such as your personal representative*
 - b. *Share information in a disaster relief situation*
 - c. *Include your information in a hospital directory*
 - If you are not able to tell us your preference, for example if you were unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- 2. Your authorization:** If you provide an authorization in writing to permit other uses or disclosures of your health information that are not described in the "Our Uses and Disclosures" section on the next page, you may revoke such authorization in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.
- 3. Cases in which we will never share your information unless you give us written permission:**
 - Marketing purposes; the sale of your information; most sharing of psychotherapy notes, and for most other sharing purposes.
- 4. Fundraising:** We may contact you for fundraising efforts, but you can tell us not to contact you again. **Continued on page 2**

G2 Dental NOTICE OF PRIVACY PRACTICES

Effective Date of This Notice: Feb 16, 2026

OUR USES and DISCLOSURES

1. **How we typically use or share your health information:** We need your consent before we disclose protected health information except in the following scenarios or the disclosure is for a medical emergency and we are unable to obtain your consent due to your condition or the nature of the medical emergency. We typically share your health information in the following ways:

T = Treating You – We can share your health information with a provider in our G2 Dental network. We can use your health information and share it with other professionals (such as other dentists, physicians or healthcare providers carrying out treatment we do not provide, pharmacists, medical or health laboratory personnel) who are treating you. We may ask for your consent prior to disclosures for treatment. **Example: A doctor treating you for an injury asks another doctor about your overall health condition.**

P = Payment/Billing – We can use and share your health information to bill and get payment from health plans or other entities. We may ask for your consent prior to disclosures for payment. **Example: We give information about you to your health insurance plan so it will pay for your services.**

O = Organizational Operations – We can use and share your health information in connection with our healthcare operations to run our practice, improve your care, and contact you when necessary. We may ask for your consent prior to disclosures for organizational operations. **Examples of healthcare operations can include: business planning, management and administrative services, quality assessment/improvement and licensing activities, evaluating our health professionals and job performance activities, conducting training programs and education, as well as accreditation, certification, licensing or credentialing activities.**

2. **Other uses and disclosures for sharing your health information:** We are allowed or required to share your information in other ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before sharing your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

a. **Public health and safety:** We can share health information about you for certain public health and safety situations such as: preventing disease; helping with product recall; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; disaster relief efforts, and preventing or reducing a serious threat to anyone's health or safety.

b. **Research:** We can use or share your information for health research if you don't object.

c. **To comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.

d. **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.

e. **Work with a medical examiner or coroner:** We can share health information with a coroner and medical examiner when an individual dies.

f. **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, unless required by law. We can also use or share health information about you with health oversight agencies for activities authorized by law. Similarly, for special government functions such as military, national security, and presidential protective services.

g. **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena. We will consult legal counsel upon receipt of such documents.

h. **Other State Law considerations:** We are required to describe any state or other laws that require greater limits on disclosure. For example, we will not share any substance abuse, HIV/AIDS, or psychotherapy treatment records without your written permission.

3. **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 through specific consent you provide to us or another third party, we will use and disclose 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.

OUR RESPONSIBILITIES

1. **Maintain privacy & security:** We are required by law to maintain the privacy & security of your protected health information.
2. **Inform you if a breach occurs:** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. **Follow notice practices:** We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not share your information other than described here *unless you tell us we can in writing.*

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Effective Date & Changes To the Terms of This Notice – The effective date of this Notice of Privacy Practices is June 03, 2019 and will remain in effect until a revised version replaces it. We can change the terms of this notice and such changes will apply to all your information we have, including health information we created or received before any notice changes. Revised notices will be available upon request, in our office, and on our web site.

G2 Dental NOTICE OF PRIVACY PRACTICES

Effective Date of This Notice: Feb 16, 2026

Privacy Officer Contact Information:

Chad Wynia

G2 Dental

1017 Centennial Drive SW

Forest Lake, MN 55025

Phone: (651) 464-2248

Fax: (651) 464-9050

frontdesk@g2dental.com

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

G2 Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. G2 Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

G2 Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages
- If you need these services, contact Chad Wynia

If you believe that G2 Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Chad Wynia, Practice Manager, 1017 Centennial Drive SW, Forest Lake, MN 55025, 651-464-2248, Fax 651-464-9050, cwynia@g2dental.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Chad Wynia, Practice Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Limited English Proficiency of Language Assistance Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-651-464-2248.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-651-464-2248.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-651-464-2248.

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-651-464-2248.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-651-464-2248.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-651-464-2248。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-651-464-2248. ማሳሰቢያ: የሚናገሩት ቋንቋ እንደ ኢትዮጵያ ከሆነ የትርጉም እርዳታ ይገኛል። በእያንዳንዱ ተዘርጋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-651-464-2248. ymol.ymo;= erh>uwdRAunDAusdmtCdAusdmtw>rRpXRvXAwvXmbl.vXmphRAeDwrHRb.ohM.vDRIAud;1-651-464-2248.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-651-464-2248

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم-1-651-464-2248.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-651-464-2248.

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-651-464-2248