G² Dental
family dentistry

Patient Registration

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

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)

POS Reorder # 1916057

Medical Health History

G² Dental
family dentistry

Patient's Name: _____

Date of Birth: _____

Physician Name: _____ Physician Telephone: _____

Physician Address: _____

Mark your response to indicate if you have had any of the following diseases or problems.
If you have a disease or problem that is not listed below, write the disease or condition in the space on the back of this form.

Date of last physical examination: _____

Yes	No	
☐	☐	Any changes in your health within the past year?

Yes	No	**Cardiovascular**
☐	☐	High/low blood pressure
☐	☐	Irregular heart beat
☐	☐	Heart surgery
☐	☐	Heart failure
☐	☐	Damaged heart valve
☐	☐	High cholesterol
☐	☐	Heart infection
☐	☐	Stroke
☐	☐	Rheumatic heart disease/ rheumatic fever
☐	☐	Heart defect/heart murmur
☐	☐	Heart trouble/heart attack/ angina
☐	☐	Chest pain
☐	☐	Pacemaker
☐	☐	Congenital heart problem
☐	☐	Mitral valve prolapse

Yes	No	**Hematologic**
☐	☐	Anemia
☐	☐	Sickle cell anemia
☐	☐	Abnormal bleeding
☐	☐	Taking blood thinners
☐	☐	Blood transfusion

Yes	No	**Respiratory**
☐	☐	Emphysema/bronchitis
☐	☐	Sleep apnea
☐	☐	Asthma/hay fever/ seasonal allergies
☐	☐	Lung/breathing problems
☐	☐	Sinus trouble
☐	☐	Shortness of breath
☐	☐	Scarlet fever
☐	☐	Persistent cough
☐	☐	Cough that produces blood
☐	☐	Tuberculosis
☐	☐	Tonsillitis

Yes	No	**Endocrine**
☐	☐	Diabetes
☐	☐	Thyroid problem
☐	☐	Hypoglycemia

Yes	No	**Renal**
☐	☐	Kidney disorder
☐	☐	Dialysis

Yes	No	**Immune**
☐	☐	Past use of steroids
☐	☐	Delayed healing

Yes	No	**Musculoskeletal**
☐	☐	Fibromyalgia
☐	☐	Lupus
☐	☐	Sjogren's Syndrome
☐	☐	Osteoporosis
☐	☐	Taken <u>any</u> meds for bone loss prevention, ie: Fosamax or Boniva
☐	☐	Arthritis/rheumatism
☐	☐	Joint replacement/implant

Yes	No	**Gastrointestinal**
☐	☐	Acid reflux/GERD
☐	☐	Irritable bowel syndrome
☐	☐	Stomach ulcer

Yes	No	**Hepatic**
☐	☐	Liver disease
☐	☐	Jaundice
☐	☐	Hepatitis

Yes	No	**Neurologic**
☐	☐	Epilepsy/seizures
☐	☐	Parkinson's Disease
☐	☐	Multiple sclerosis
☐	☐	Headaches/migranes

Yes	No	**Skin**
☐	☐	Hives or skin rash
☐	☐	Other skin lesions
☐	☐	Cold sores/fever blisters

Yes	No	**Eyes/Ears**
☐	☐	Glaucoma
☐	☐	Impaired vision/contact lens
☐	☐	Impaired hearing/hearing aids

Yes	No	**Mental Health**
☐	☐	Bipolar disorder
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorders
☐	☐	Sleep disorder
☐	☐	Dementia
☐	☐	Learning disorders
☐	☐	Mental health care
☐	☐	Nervousness

Yes	No	**Infections**
☐	☐	HIV positive/AIDS
☐	☐	Sexually transmitted disease

Yes	No	**Allergies**
☐	☐	Local anesthetic
☐	☐	Antibiotics/penicillin
☐	☐	Aspirin/ibuprofen
☐	☐	Acetaminophen (Tylenol)
☐	☐	Codeine/narcotics
☐	☐	Metals
☐	☐	Iodine
☐	☐	Latex
☐	☐	Sulfa drugs
☐	☐	Other _____
☐	☐	Food/environmental please list _____

Yes	No	**Other**
☐	☐	Cancer
☐	☐	Cancer treatment/Radiation
☐	☐	Chemotherapy (Cancer, Leukemia)
☐	☐	Tobacco use
☐	☐	Alcohol use
☐	☐	Chemical dependency
☐	☐	Street/recreational/illicit drug use
☐	☐	Back problems
☐	☐	Tumors
☐	☐	Swelling of feet/ankles/ hands
☐	☐	Fainting/dizzy spells
☐	☐	Cortisone treatment
☐	☐	Unexplained weight loss
☐	☐	Taken Redux

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?	☐	☐
If yes: do you wear a CPAP?	☐	☐
A sleep appliance?	☐	☐
Have you noticed or been told of any of the following while you are sleeping?		
Snoring, heavy or loud breathing?	☐	☐
Break or pause in breathing?	☐	☐
Gasp, choke, or struggle to breathe?	☐	☐
Restless or agitated sleep? Grinding teeth?	☐	☐
Abnormal head posture (hyper-extension, etc.)?	☐	☐
Have you noticed any of the following during the day?		
Difficulty waking?	☐	☐
Wake with headaches and/or sore teeth/jaw muscles?	☐	☐
Tired during day?	☐	☐
Teeth sensitive to cold?	☐	☐
Gum tissue recession?	☐	☐

Women Only:

Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you using a birth control method?	☐	☐

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? _____

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

	YES	NO
Have you had:		
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

G² Dental family dentistry

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

POS Reorder # 1916062

G2 Dental

1017 Centennial Drive SW, Forest Lake, MN 55025

Notice of Privacy Practices Acknowledgement Form

Patient's Name: (First Name, Last Name):	Date of Birth:

I understand that as part of my care, G2 Dental creates and maintains health records that describe my health history, symptoms, examinations, test results, diagnosis, procedures, treatment, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at G2 Dental (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by a third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from G2 Dental defines more information regarding the use and disclose of my protected health information as well as my rights to my health information. By signing this, I acknowledge that G2 Dental has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosures for treatment, payment, and healthcare operations purposes for G2 Dental.
I authorized G2 Dental to communicate regarding my treatments to the following individual(s):

_____

_____

I understand that I am ultimately responsible for all charges incurred for dentistry performed at G2 Dental office including balances left after insurance payment has been received.

I understand that G2 Dental communicates through text messaging about appointment reminders that contain patient specific information. I agree to the communication through text messaging unless I select the box below.

☐ I do not wish to receive text message communication for appointment reminders (Check to Opt Out)

This consent will continue forever unless I cancel it by writing to: G2 Dental, 1017 Centennial Drive SW, Forest Lake, MN 55025; if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation. I don't want the consent to never expire, please expire the consent as of: _____.
I understand that I can get an electronic copy of the Notice of Privacy Practices at www.g2dental.com.

_____ _____

Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect) _____

Optional: Please e-mail me a copy of the Notice of Privacy Practices to the following e-mail address:
_____

Internal Use:

If patient refuses to sign, please have 2 staff members of G2 Dental Sign Below:

_____ _____

Staff's Signature Staff's Signature

Reason for Refusal of Signature: _____

G2 Dental NOTICE OF PRIVACY PRACTICES

Effective Date of This Notice: Feb 10, 2025

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 10, 2025

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 you 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 you 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 you 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.

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.

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.

XIYYEEFFANNAA: 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. ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-651-464-2248

번으로 전화해 주십시오.

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