WISCONSIN FAMILY DENTAL

PATIENT INFORMATION

First (Legal) Name _____ Last Name _____ □ Male □ Female □ Other

Preferred Name_____ Birth Date ____/____/_____ Social Security # _____

Home # _____ Cell #_____ Work #_____

Email Address _____

Mailing Address _____City _____ State _____ Zip _____

Is Billing Address Same as Mailing (If no, please enter billing address below)? □ Yes □ No

Billing Address _____City _____ State _____ Zip _____

How did you hear about our office? □ Patient □ Doctor □ Internet Search □ Social Media □ Website

□ Flyer □ Event □ Paper/Magazine □ Insurance Provider □ TV □ Radio □ Signage

If patient or doctor referral, please let us know who: _____

EMERGENCY INFORMATION

Emergency Contact _____ Relationship _____

Emergency Number_____

RESPONSIBLE PARTY INFORMATION

□ CHECK IF SAME AS ABOVE.

Name _____ Birth Date ___/___/_____ Relation _____

Phone _____

DENTAL INSURANCE INFORMATION

Please provide a copy of your dental insurance card <u>OR</u>
fill out the information below if a card is not available.

Primary Dental Insurance

Carrier _____ Phone _____ Group Name/Employer _____

Group # _____ ID #_____

Secondary Dental Insurance

Carrier _____ Phone _____ Group Name/Employer _____

Group # _____ ID #_____ Subscriber's Name _____

Subscribers's Birth Date ___/____/_____ Relation to Patient _____

TO ENSURE YOU GET THE BEST COVERAGE, PLEASE ALSO PROVIDE A COPY OF YOUR MEDICAL INSURANCE CARD.

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. By signing below, you also acknowledge that you will not hold the dentist, the dental practice, or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

I agree that the information provided in this form is correct to the best of my knowledge.

Signature_____ Date___/___/____

WISCONSIN FAMILY DENTAL

Patient Name _____ **Birth Date** _____/_____/_____

MEDICAL HISTORY

Primary Physician _____ Clinic Name_____
Clinic Phone _____

ALLERGIES (check all that apply)

□ Acetaminophen/Tylenol
□ Ibuprofen/Motrin/Advil
□ Dogs
□ Codeine
□ Erythromycin
□ Environmental
□ Fluoride
□ Acrylic
□ Latex
□ Local Anesthetic
□ Metals
□ Penicillin
□ Sulfa
□ Other_____

CONDITIONS (check all that apply)

□ Abnormal Bleeding
□ AIDS/HIV
□ Alcohol/Drug Abuse
□ Alzheimer's/Dementia
□ Anemia
□ Anxiety
□ Arteriosclerosis
□ Arthritis
□ Asthma
□ Autoimmune Disease
□ Back Problems
□ Blood Clotting Problems
□ Blood Disease
□ Blood Thinners
□ Respiratory Disease
□ Chemotherapy/Radiation
□ Cardiovascular Disease
□ Congestive Heart Failure
□ Damaged Heart Valves
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fainting or Seizures
□ Frequently Dry Mouth
□ Reflux/Frequent Heartburn
□ Glaucoma
□ Gout
□ Hearing Difficulties
□ Heart Attack
□ Heart Murmur
□ Heart Rhythm Disorder
□ Hemophilia
□ Hepatitis or Liver Disease
□ High Blood Pressure
□ Joint Replacement
□ Kidney Problems
□ Low Blood Pressure
□ Multiple Sclerosis
□ Neurological Disorders
□ Osteoporosis/Paget's
□ Other Heart Defects
□ Pacemaker
□ Pregnant
□ Premed Requirement
□ Recurrent Infections
□ Rheumatic Heart Disease
□ Severe Headaches
□ Sinus Trouble
□ Stroke
□ Thyroid Problems
□ TMJ Disorder
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Wheelchair Access

□ Other_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? □ Yes □ No

If yes, please explain_____

Have you hadan orthopedic total joint (hip, knee, elbow, finger) replacement? □ Yes □ No

If yes, please list when and any complications_____

Has a physician or prior dentist recommended that you take antibiotics prior to your dental treatment?

□ Yes □ No

If yes, please provide the name of the provider making the recommendation_____

Are you taking any medications? □ Yes □ No

If yes, please list all including vitamins/supplements_____

Have you ever taken FosaMax®, Boniva®, Actonel®, or other medications containing bisphosphonates?

□ Yes □ No

Have you had any adverse reactions to medication or injections? □ Yes □ No

If yes, please explain_____

Do you have sleep apnea? □ Yes □ No

Do you use tobacco (smoking, snuff, chew, bidis, vaping)? □ Yes □ No

If yes, how long have you been using and how much per day_____

Are you pregnant? □ Yes □ No

If yes, how many weeks_____

Are you nursing? □ Yes □ No

Any other condition you think we should know about?_____

Preferred Pharmacy_____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below, you also acknowledge that you will not hold the dentist, the dental practice, or any other member of the practice staff responsible for any action or lack of action because of errors or missed omissions that may have been made during the completion of this form.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

WISCONSIN FAMILY DENTAL

Patient Name _____ **Birth Date**_____/_____/_____

DENTAL HISTORY

Previous Dental Office _____ Office Phone # _____
Name of Previous Dentist_____ Date of Last Cleaning _____
Date of Last Exam_____ Date of Last Bitewing X-Rays _____ Date of Last Panoramic X-Ray_____

Previous History (Check all that apply)**:**

□ Periodontal Treatment □ Wearing Night Guard(s) □ Injury to Head/Neck/Mouth
□ Orthodontic Treatment □ Partial Dentures □ Problems With Previous Dental Treatment
□ Wearing Retainer(s) □ Complete Dentures

Current Dental Health (Check all that apply)**:**

□ Dental Pain/Discomfort □ Frequent Dry Mouth □ Mouth Sores/Ulcers
□ Hot/Cold, Pressure, Sweets Sensitivity □ Food Catches Between Teeth □ Gums Bleed
□ Earaches or Neck Pain □ Clicking/Popping in Jaw □ Grind Teeth
□ Home Water Supply Is Fluoridated

□ Any other condition we should know about_____

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I agree that the information provided in this form is correct to the best of my knowledge.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

Wisconsin Family Dental
435 W Oak St
Suite G
Cottage Grove, WI 53527
Ph : (608) 839-9200
Email: info@wifamilydental.com

Patient: _____
Address: _____
_____
_____

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (03/25/2022), and will remain in effect until we replace it.

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

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

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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

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

Healthcare operations: We may use or disclose your health information in connection with our

healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification licensing or credentialing activities.

Our Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. You revocation will not affect any use of disclosures permitted by your authorization while it was in affect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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

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

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format your request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge

you for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information at the end of this Notice for a full explanation of our fee structure.

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

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

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

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by Electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information on our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services upon request.

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

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
202/619-0257
Toll free: 1/877-696-6775

ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received the office's Notice of Privacy Practices.

Signature_____ Date____/____/_____

WISCONSIN FAMILY DENTAL

CONSENT TO SHARE INFORMATION

By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in our care or payment for that care. Please list names and relationship of all parties who you consent for our practice to discuss dental treatment and billing records with:

_____

_____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed above. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

_____

Please Print Name

_____

Patient/Guardian Signature

_____

Date