



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 OR
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 ___ / ___ / ___



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 had an 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 _____

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.

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



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



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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026, 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, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care.

We may disclose your health information to your family or friends, or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

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.

OTHER USES AND DISCLOSURES OF PHI.

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and

notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if 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 using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

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 Notices of Privacy Practices.

Signature

Date