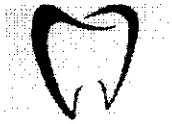


Wise Dental 1808 Chico Hwy, Bridgeport Tx 76426 940-683-3233

Please fill the following information so that we can best serve you. Thank you

PATIENT:

LAST NAME:_____ FIRST:_____ INITIAL:_____

How do you wish to be addressed? _____

DOB _____ **Marital Status**: θSingle θMarried θDivorced **(Child)**

Address _____City_____State_____ Zip _____

Telephone (Home) _____ _____ _____ (Work) _____ _____ _____ (Mobile)_____ _____ _____
Email: _____ Employer: _____
Occupation:_____ SSN: _____

Dental Insurance Co. _____ Is patient covered by another dental insurance? θYes θNo InsuranceCo:_____

Name of Subscriber: _____ DOB of Subscriber:_____

SSN or ID#: _____ Employer:_____

RESPONSIBLE PARTY OR PARENT INFORMATION:

LAST NAME:_____ FIRST:_____ INITIAL:_____

DOB: _____ Address _____
City_____ State_____ Zip _____ Telephone (Home) _____ _____ _____
(Work) _____ _____ _____ (Mobile)_____ _____ _____ Email: _____
Employer: _____ Occupation:_____ SSN: _____
Dental Insurance Co. _____

EMERGENCY CONTACT INFORMATION:

LAST NAME:_____ FIRST:_____ DOB: _____
Address _____ City_____ State_____ Zip _____
Telephone (Home) _____ _____ _____ (Work) _____ _____ _____ (Mobile)_____ _____ _____
Email: _____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility:

MEDICAL HISTORY

☐Y☐N Under a physician's care now?

☐Y☐N Any hospitalization in the past 5 years? _____

☐Y☐N Any serious illnesses/surgeries? _____

☐Y☐N Use tobacco in any form? If Yes, Type: _____

☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐ ☐ Y N Currently nursing? ☐ ☐ Y N Currently pregnant? Due Date: _____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

(CHECK ALL THAT APPLY):

☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐FREQUENT HEADACHES	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐NONE

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	
☐OTHER – PLEASE LIST:				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

I acknowledge that the questions have been answered to my satisfaction. I will not hold my dentist or staff responsible for any action that is a result of errors or omissions that I may have made on this form.

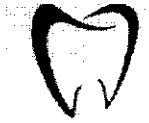
Signature of Patient/Legal Guardian: _____ Date_____

Reviewed by: _____ _____

Doctors Signature Date

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.



Wise Dental 1808 Chico Hwy., Bridgeport Tx 76426 940-683-3233

TERMS OF AGREEMENT AND UNDERSTANDING WITH WISE DENTAL:

I understand that I must read the following section and sign that I have read it before any treatment will be provided. I understand that Wise Dental is not making any promise that everything will be perfect and all the work done is going to be permanent. I realize that my natural teeth can decay, chip, crack, break or give way, despite the best efforts of the doctor and all associated people involved in the care of my teeth. The results cannot be guaranteed or predicted with certainty. I understand that the doctor has her/his own limitation despite the best effort made by her/him and may not be able to provide what I desire or what I think I deserve. I understand that any warranties on dental materials or procedures are good only if I keep up with my regular scheduling for cleaning , scaling and root planning (if needed) and follow up office visits as advised. I have read the above and I agree to consider these concepts in my expectations.

Signature:_____ Date:_____

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT AT WISE DENTAL:

Your Dental Health is very important to us. We also want you to be comfortable knowing that nothing is more crucial to us that protecting you and your health. We are here to help you afford your dental treatment. When the type of treatment has been decided upon, time will be appointed to complete the treatment. All financial arrangements will be made with you during that time. We are required to obtain consent from you for all the following. Please read and sign the bottom of the page. Please ask us if you have any questions.

1. **Use of the diagnostic tools**: I hereby authorize the Dentist and staff at Wise Dental to take x-rays, study models, photographs, and any other diagnostic aids that may be appropriate to make a thorough diagnosis of my dental needs.
2. If you are signing for a minor or you are the caregiver please write the patients name here:

   _____
3. **Agreeing to treat**: Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of nontreatment.
4. **Disclosure of Health history**: I have disclosed my complete health history, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.
5. **Local Anesthetic**: I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

6. **Saving my life:** I authorize the doctor and any other qualified assistants or medical professionals to administer any needed medication that may be required as a life-saving measure and to perform any compulsory life-saving procedures
7. **Personal information:** I give consent to the doctor's or designated staff's use and disclosures of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed.
8. **Payment methods:** I understand that I can make payments by cash, credit card or debit card on the day of the treatment. On extensive treatment I can secure a third party financing. I am aware that Wise Dental offers Care Credit as an option and I can get a financial plan with low monthly rate with no interest for 6 months. I can chose to put the entire amount on Care Credit and make payments to the lending institute. I understand that all financial arrangements and insurance questions will be discussed with me in advance.

Patient's Signature: _____ Date: _____

Responsible Party's Signature: _____ Relationship: _____

Wise Dental
1808 Chico Hwy
Bridgeport, TX 76426
www.wisedentaltx.com
Privacy Officer Phone: 210-616-2030
Privacy Officer Email: admin@hcr-audit.com

Authorization for Use or Disclosure of Protected Health Information

I hereby voluntarily authorize the disclosure of information from my health record. I understand that I may revoke this authorization at any time in writing and submitted to the Covered Entity above, except to the extent that action has been taken in reliance on this authorization.

Name of Patient

Signature of Patient, Parent (if patient is a minor), or Legal Representative

Date

The information from my health record is to be disclosed by the Covered Entity above and provided to the following:

Name of Person/Organization

Street Address

City/State/ZIP

Name of Person/Organization

Street Address

City/State/ZIP

The information to be disclosed from my health record is limited to (check):

- ☐ Only information related to: _____
- ☐ Only for the period from: _____ to _____
- ☐ Entire health record

Wise Dental
1808 Chico Hwy
Bridgeport, TX 76426
www.wisedentaltx.com
Privacy Officer Phone: 210-616-2030
Privacy Officer Email: admin@hcr-audit.com

Notice of Privacy Practices Acknowledgement

I acknowledge receiving the practice's "Notice of Privacy Practices" dated 10/5/2020.

Name	Signature	Date

1808 Chico Hwy., Bridgeport Tx 76426 940-683-3233 www.wisedentaltx.com

Social Media Informed Consent

Wise Dental is pleased to participate in social media outlets such as Facebook, Instagram, YouTube, Google+, etc. Through these venues, we share staff pictures, office updates, new contests, and other fun and helpful information updates that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts welcoming new patients to our practice, congratulating patients completing their treatment, and posting photos of our patient's beautiful new smiles.

θ I give my consent to allow Wise Dental to post updates or photographs of me/my child on social media.

θ I do not give my consent to my/my child's information being shared on social media.

Name of Patient

Signature of Patient or Responsible Party Date

****Parents With Children Under 18****

- Children under the age of 18 must be accompanied by a parent or guardian to the office. You must stay with your child during the appointment. You cannot drop your child off and leave them unsupervised.
- The law states that we may not treat them without permission of a responsible adult. Children under 18 who come without a parent or guardian ***cannot*** be seen on that day. _____ **Initials**

- Due to safety concerns, we cannot have unsupervised children at the office. Please make prior arrangements for supervision of your children during dental visits.

Please list who can bring your child, sign consent forms, and make any dental decisions for your child if you cannot be present during their appointment.

Person 1: _____ Relationship: _____

Person 2: _____ Relationship: _____

Person 3: _____ Relationship: _____

Signature _____ **Date:** _____