W.I.S.E
ORAL SURGERY & DENTAL IMPLANT SPECIALISTS

Trussville & Gardendale
5750 Bentley Way
Trussville, AL 35173
P (205) 900-9473 F (205) 729-7222
trussville@wiseomfs.com

Prattville & Montgomery
711 Kornegay Dr.
Prattville, AL 36066
P (334) 325-5810 F (334) 325-5812
prattville@wiseomfs.com

Birmingham & Hoover
2074 Valleydale Rd.
Birmingham, AL 35244
P (205) 289-8850 F (205) 289-8658
hoover@wiseomfs.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date: ___ / ___ / _____

Locations: ◯ Trussville & Gardendale ◯ Prattville & Montgomery ◯ Birmingham & Hoover

◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. First Name: _____ MI: ___ Last Name: _____

Sex: ◯ Male ◯ Female Birthdate: ___ / ___ / _____ Age: _____ Soc. Sec. #: _____ Email: _____

Street: _____ Apt.: _____ City: _____ State: _____ Zip: _____

Home Tel.: _____ Cell: _____ Have you ever been a patient of our practice? ◯ Yes ◯ No

Referred By: _____ ◯ General Dentist/Dental Specialist ◯ Friend ◯ Online ◯ Insurance Company

Dentist: _____ Medical Dr.: _____

Employer: _____

In case of emergency, please contact: _____ Tel: _____ Relation: _____

MEDICAL HISTORY

Your health history may affect your oral surgery procedure or the medications we prescribe. We appreciate your answers to the following questions.

List All Medications Taken:

_____

_____

_____

Are you allergic to any of the following?

◯ No Known Allergies ◯ Penicillins ◯ Sulfa ◯ Soy ◯ Aspirin ◯ Latex ◯ Eggs/yolk ◯ Sulfites ◯ Nickel
◯ Local Anesthesia ◯ Sodium Pentothal/Valium/Other tranquilizers ◯ Codeine or other narcotics.

Other known allergies? Please list: _____

Have you ever taken bone density medications, RANKL inhibitors, or bisphosphonates such as FOSAMAX, BONIVA, ACTONEL, PROLIA, XGEVA, EVISTA, or similar?
◯ Yes ◯ No If yes, list medication(s) and duration/last use: _____

Are you taking any blood thinners such as COUMADIN, PLAVIX, ASPIRIN, XARELTO, ELIQUIS, BRILINTA, AGGRENOX, or similar?
◯ Yes ◯ No If yes, list blood thinner(s): _____

Have you ever had radiation treatment for cancer to the head or neck?
◯ Yes ◯ No If yes, please list treating doctor's name and phone#: _____

Please provide us with your pharmacy name & number: _____

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PATIENT REGISTRATION FORM (CONT.)

FINANCIAL POLICY & FACTS ABOUT INSURANCE

Your insurance is a contract between you, your employer, and the insurance company. We ARE NOT a party to the contract. We will work with all insurance companies; however, some of the companies will only reimburse doctors who have agreed to accept their fees in order to attract more patients. We will do our best to assist you with your insurance information; however, the ultimate responsibility of understanding your reimbursement policies lies with the patient.

As a courtesy to our patients, we will submit and facilitate insurance claims; however, it is common for insurance companies to delay payment, and payment is ultimately the responsibility of the patient. Final payment is due no later than sixty (60) days past treatment, regardless of insurance status.

It has been the experience of many doctors that some insurance companies tell their customers that "fees are above the usual and customary" rather than saying, "our benefits are low." Wise Oral surgery & Dental Implant Specialists is committed to offering exceptional care with fees that are comparable in the region.

Unfortunately, insurance benefits will almost always be less than anticipated. These benefits are negotiated by your employer and insurance company. For your convenience, we will ESTIMATE what your insurance will cover. This is JUST AN ESTIMATE. Your insurance company will determine your benefits. This ESTIMATE will be due at the time of service.

I hereby consent to being contacted by email or telephone at any email address or telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf. I understand and agree that such contact may be initiated by our practice or its designated agents, such as billing companies, and that the methods of contact may include the use of text messages, which may result in data charges. I also consent to receiving emails at any email address provided by me.

FINANCIALLY RESPONSIBLE SIGNATURE **DATE**

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PATIENT REGISTRATION FORM (CONT.)

NOTICE OF FILMING AND PHOTOGRAPHY

When you enter WISE Oral and Facial Surgery, you are entering an area where photography, audio, and video recording may occur.

By entering the premises, you consent to interview(s), photography, audio recording, video recording and its/their release, publication, exhibition, or reproduction to be used for news, web casts, promotional purposes, telecasts, advertising, inclusion on websites, social media, and any other purpose by WISE and its affiliate and representatives. Images, photos and/or videos may be used to promote similar WISE events in the future, highlight the event and exhibit the capabilities of WISE. You release WISE, its officers and employees, and each and all persons involved from any liability connected with the taking, recording, digitizing, or publication and use of interviews, photographs, computer images, video and/or sound recordings.

By entering the WISE premises, you waive all rights you may have to any claims for payment or royalties in connection with any use, exhibition, streaming, web casting, televising, or other publication of these materials, regardless of the purpose or sponsoring of such use, exhibiting, broadcasting, web casting, or other publication irrespective of whether a fee for admission or sponsorship is charged.

You also waive any right to inspect or approve any photo, video, or audio recording taken by WISE or the person or entity designated to do so by WISE. You have been fully informed of your consent, waiver of liability, and release before entering

PATIENT/GUARDIAN SIGNATURE **DATE**

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PATIENT REGISTRATION FORM (CONT.)

AUTHORIZATION

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment.

INITIAL **WITNESS** **DOCTOR**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

INITIAL

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR) **DATE**

REVIEWED BY **DATE**

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PATIENT REGISTRATION FORM (CONT.)

HIPAA COMPLIANCE PATIENT CONSENT

Our Notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone/text/email you regarding your appointment? ..... ◯ Yes ◯ No

May we send e-statements in regards to your account? ..... ◯ Yes ◯ No

May we leave a message on your answering machine or voicemail? ..... ◯ Yes ◯ No

May we discuss your medical condition with any member of your family? ..... ◯ Yes ◯ No

IF YES, please name the members allowed:

_____

This consent was signed by (please print name) : _____

_____ _____

SIGNATURE **DATE**

_____ _____

WITNESS **DATE**