Welcome

Thank you for choosing us as your oral health care provider. Please take a few moments to fill out this form as completely as you can. If you have any questions, please feel free to ask. We look forward to being of service to you and welcome you as a part of our family of patients.

Patient Information

Name: _____ Soc. Sec # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email address: _____ Date of Birth: _____

Sex: M F Marital Status: Single Married Widowed Separated Divorced

Patient employed by: _____ Occupation: _____

How do you plan to pay for today's visit? _____ Cash/Check _____ MC/Visa/Debit

Dental Insurance

Person responsible for account: _____

Relationship to patient:_____ Date of Birth:_____ Soc. Sec. #:_____

Responsible party's employer: _____ Business phone:_____

Insurance company: _____ Phone number: _____

Group number: _____ Patient ID: _____

Name of other dependants under this plan: _____

Please complete below if patient is a minor (under 18 years):

Mother's Name: _____ Soc. Sec. #:_____ Date of Birth:_____ Work phone: _____

Father's Name: _____ Soc. Sec. #:_____ Date of Birth:_____ Work phone: _____

Wake Forest Dental Arts

Craig A. Winkelmann, DDS, FAGD and Associates

Medical History

Please take a moment to answer the following important health related questions. Your answers will help us to provide you with the best in patient care.

Your Primary Physician's Name & Phone Number: _____

Conditions	**Conditions**	**Conditions**
Y N Heart Murmur	Y N Liver Disease	Y N Artificial Heart Valve
Y N Venereal Disease/STD's	Y N Kidney Problems	Y N Artificial Bones/Joints
Y N Ulcers	Y N HIV+/AIDS	Y N Arthritis
Y N Tuberculosis	Y N High Blood Pressure	Y N Angina Pectoris
Y N Thyroid Problems	Y N Hepatitis B	Y N Anemia
Y N Stroke	Y N Hepatitis A	Y N Allergies
Y N Sinus Problems	Y N Hepatitis C	Y N Sickle Cell Anemia
Y N Hemophilia	Y N Abnormal Bleeding	Y N Cancer-Chemotherapy
Y N Heart Attack/Date: _____	Y N Reflux	Y N Blood Transfusion
Y N Shingles	Y N Hay Fever	Y N Asthma
Y N Seizures	Y N Glaucoma	Y N Fainting Spells
Y N Rheumatic Fever	Y N Frequent Headaches	Y N Drug Abuse
Y N Radiation Therapy	Y N Fever Blisters	Y N Low Blood Pressure
Y N Colitis	Y N Psychiatric Problems	Y N Diabetes
Y N Pace Maker	Y N Emphysema	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Difficulty Breathing	Y N Dental Premed

Do you smoke or use tobacco: YES NO

Have you ever used the drug "Fen-Phen"? YES NO

*Any other condition not listed, please describe here: _____

_____

Allergies:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Sulfa
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline

Other: _____

Females Only:

Y N Are you taking birth control pills?
Y N Are you nursing?
Y N Are you pregnant?
# of weeks _____

Please list any medications you are currently taking: _____

_____

I request and authorize Dr. Winkelmann and/or his associates and hygienists to examine, my teeth, dignose my condition and render necessary dental treatment as approved by me. I further request and authorize the taking of dental x-rays and photographs as may be considered necessary for diagnostic or educational purposes. I will be fully responsible for any charges incurred for all treatment provided while I am a patient of this office.

Signature: _____ Date: _____

Print Name: _____

Wake Forest Dental Arts

Craig A. Winkelmann, DDS, FAGD and Associates

NEW PATIENT INTERVIEW

Please tell us about yourself:

1) What is your occupation? _____

2) What are your interests and hobbies? _____

3) What are your top dental concerns? _____

We'd like to know about your past dental history:

1) Date of your last visit to a dentist? _____

2) Date of your most recent dental x-rays (if known): _____

3) How many times a day do you brush your teeth? _____ Floss? _____

4) Are you happy with the appearance of your teeth? Yes No

    a. If not, please explain so we can help you? _____

    _____

Some additional helpful information:

1) How did you hear about our office? _____

2) We value referrals from our patients. If an existing patient referred you, please let us know who it is so we may thank them? _____

3) Please let us know how we may make your visits with us more enjoyable: _____

    _____

4) Is there anything else we should know that we have not asked on this or other forms?

    _____

Wake Forest Dental Arts

Office and Financial Policies

Thank you for choosing us as your oral health care provider. Our office hours are designed to allow convenient scheduling of your appointments. We strongly value your time and we will do our best to keep you from waiting when you arrive for your schedule appointment. However, there are times when a procedure may take longer than expected or we are treating a patient with an unexpected emergency that requires immediate attention. We will make every effort to contact you ahead of time if this occurs.

Appointments_____

Making an appointment is like making a contract with us. We reserve a treatment room, the doctor's or hygienist's time and the time for the support staff to provide your care. We do understand that unforeseen things come up and request a 48 hour notice that you cannot keep your appointment. We do not accept e-mail or voicemail changes for appointments. Please call the office and speak to us directly so we can best serve you.

Broken/Missed Appointments_____

A broken appointment is one that you did not show up for or did not give us the requested 48 hour notice mentioned above. There is a $75 charge for a broken appointment with the doctor and a $35 charge for a broken appointment with our hygienists. This fee must be paid prior to rescheduling your appointment.

Insurance_____

As a courtesy to you, we will file your insurance claim on your behalf. We are not responsible for the outcome of the transaction. In the event your insurance company declines payment for your treatment, you will be responsible for the entire balance. Your insurance plan is a contract between you or your employer and the insurance company. Our practice is not party to that agreement.

We have no control over your insurance contract. Often there is a "Least Expensive Alternative Treatment" clause that allows an insurance company to pay less that the service you agreed to. Please read and understand your insurance policy.

Payment for Services_____

Payment is expected on the day of your treatment. If you have insurance, this amount will be your estimated co-payment.

We file insurance claims electronically which expedites their processing time. All unpaid claims are to be paid within 60 days of the time treatment was rendered. All over 60 day claims will have a $50 rebilling fee added. Any fees that are not paid by 90 days since the day treatment was provided will be sent to a collection agency.

To prevent rebilling fees or having your account turned over to a collection agency, we can securely maintain your credit card on file and will only bill those charges that you authorize. If you desire to use this option, please complete the "Credit Card Preauthorization" form.

Refunds_____

Providing dental care is very expensive in terms of staff time, facility expenses, lab expenses, etc. so there are no refunds of fees collected. Our ultimate goal is to provide optimum care for each of our patients and ensure your satisfaction. Like in any health care setting, there are some outcomes that are less than desirable. We understand this and hope you do too. We will do everything in our collective experience to have you satisfied with your treatment.

I have read and understand these policies. I have had the opportunity to ask questions about these policies before signing this form.

Signed:_____ **Date:**_____

Wake Forest Dental Arts

Craig Winkelmann, DDS, FAGD and Associates
12520 Capital Boulevard, Suite 101, Wake Forest, NC 27587 Tel: 919.570.9100

Credit Card Preauthorization

I authorize Wake Forest Dental Arts (Winkelmann and Associates, DDS, PA) to charge my credit card as detailed below:

One Time Authorization:

☐ Please cover any unpaid balance after insurance payment only for this current treatment not to exceed $_____(visit total). I understand that if my insurance carrier has not issued benefits within 60 (sixty) days, my credit card will be charged for the visit and any future benefits will be sent to me.

Continuous Authorization:

☐ Please keep this signature on file to cover any unpaid balance after insurance payment for any treatment performed in this office.

Patient Name:_____

Responsible Party Name:_____Relationship_____

Credit Card Information

◯ Visa ◯ Master Card ◯ Discover Card ◯ American Express

Card Holder's Name:_____

Card #_____ Expiration Date_____

Adress:_____

_____

Work Phone#_____Home Phone#_____Cell Phone #_____

Card Holder Signature:_____ Date:_____

Staff Initials_____Date:_____

☐ Copy to Patient, Original filed

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.

7. We agree to provide patients with the access to their records in accordance with the state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____date_____do hereby consent and **acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**