Welcome

@DENTAL
1701 Green Valley Parkway, Suite 4D
Henderson, NV 89074

Patient Information (Confidential)

Today's Date: ________________

*Name:*____________________________________ *Birthdate:* ____________ *SSN:* ____________________

Address: __________________________________ *City:* ___________________ *State:* _____ *Zip:* __________

Home Phone: ______________________________ *Cell Phone:*_____________________________________

Email Address: _____________________________________

Patient's or Parent's Employer: __________________________________*Work Phone:* ______________*ext*______

Business Address: __________________________________ *City:* ______________ *State*_________ *Zip:* __________

Spouse or Parent's Name ____________________ *Employer:* ___________________ *Work Phone:* _______________

Whom may we thank for referring you? ____

Person to Contact in the case of an emergency: ________________________________ *Phone:* ____________________

Responsible Party (If different from Patient)

Name of Person Responsible for this account: __________________________ *Relationship to you:* ____________

Address: ____ *Home Phone:* __________________

Driver's License #: _______________ *Birthdate:* ____________

Employer: _______________________________ *Work Phone:* _________________ *SSN:* __________________

Is this person a patient of this office? *Yes* ☐ *No* ☐

Insurance Information

Name of Insured: ___________________________________ *Relationship to Patient:* _____________________________

Birthdate: ___________________ *Insurance Company Name:* ____

Next page please

@DENTAL Patient Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain:

____

____

3. Are you taking any medication?	☐	☐

If so what are they:

____

Any OTC or non-prescription drugs?	☐	☐

If so what are they? ______________________________

4. Are you allergic to/had a reaction to any of the following:

	Yes	No
Local Anesthetics (e.g., Novocaine)	☐	☐
Penicillin	☐	☐
Other Antibiotics	☐	☐
Please List______________________________		
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________________		

5. **Women Only:**

a) Pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Taking oral contraceptives?	☐	☐
d) Wearing a patch?	☐	☐
e) Taking anything for bone health?	☐	☐

Do you have or have you had any of the following?

	Yes	No
Low Blood Pressure	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Bypass Surgery	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Angina	☐	☐
Mitral Valve Prolapse	☐	☐

	Yes	No
Asthma	☐	☐
COPD	☐	☐
Chronic Bronchitis	☐	☐
Respiratory Problems	☐	☐
Epilepsy/Convulsions	☐	☐
TB	☐	☐
Arthritis	☐	☐
Hip/Joint Replacement	☐	☐
Knee Replacement	☐	☐
Hepatitis	☐	☐
TYPE____________________		
Blood Thinners?	☐	☐

	Yes	No
Cancer	☐	☐
Radiation treatment	☐	☐
Liver disease	☐	☐
Kidney diseases	☐	☐
Fainting/Seizures	☐	☐
Stomach problems	☐	☐
GERD	☐	☐
Thyroid problems	☐	☐
Diabetes	☐	☐
AIDS/HIV Infection	☐	☐
STD	☐	☐

@DENTAL: Patient Dental History

Previous Dentist and Location ____________________________ *Date of Last Exam:* ________________

	YES	NO
1. Gums bleed while brushing or flossing?	☐	☐
2. Teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Pain in any teeth?	☐	☐
4. Sores or lumps in or near your mouth?	☐	☐
5. Any head, neck, or jaw injuries?	☐	☐
6. Any of the following problems in your jaw?		
Clicking?	☐	☐
Pain in ear, joint or side of face?	☐	☐
Difficulty in opening or closing?	☐	☐
Chewing problems?	☐	☐

	YES	NO
7. Clench or grind your teeth?	☐	☐
8. Any difficult extractions in the past?	☐	☐
9. Any prolonged bleeding after an extraction?	☐	☐
10. Have you had braces in the past?	☐	☐
11. Have you had any periodontal treatment?	☐	☐
Deep cleaning under local anesthesia?	☐	☐
Periodontal Surgery?	☐	☐

12. How long do you want to keep your teeth? _____________

13. Anything you would change about your smile?

____

____

____

Authorization and Release

I have read the above questions and truthfully answered them to the best of my ability and knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the release of any information while under Dr. Wineman's care (diagnosis and treatment records rendered to me or any of my children) to third party payers and/or other required dental practitioners. I authorize and request my insurance company to pay the dentist directly or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (or parent if patient is a minor) Date

Next page please

@DENTAL
1701 Green Valley Parkway, Suite 4D
Henderson, NV 89074

INFORMED CONSENT

All the information on the previous pages of this packet is true and correct to the best of my (the patient's) knowledge. I authorize my physician or dentist to provide all necessary medical and/or dental information to another provider and they can be contacted for advice or details of my treatment/care. I further authorize the taking of radiographs, photographs, and other diagnostic measures as deemed appropriate for a thorough evaluation and for teaching and educational purposes. Authorization is also given for dental treatment to be rendered by the dentist and the office staff.

The dental team believes you should play an active role in your treatment and you should give us your informed consent prior to beginning any procedure. The purpose of this form is to inform you of the risks that you may incur in course of treatment, such as endodontic therapy (root canal treatment) or oral surgery.

Root canal treatment is done when the nerve of the tooth is infected with the goal of maintaining the tooth in the mouth. The nerve and blood vessels of the tooth are removed and an inert material is placed into the canal space. While root canal therapy is quite predictable and enjoys a high success rate, even under the best circumstances, endodontic therapy occasionally fails. Re-treatment of the affected tooth or a treatment called an apicoectomy may be required. An apicoectomy is where the surgeon removes the root tip of the tooth in question and then may place a filling into the root tip. Occasionally the decay/infection/crack may be too advanced for the dental team to save the tooth and it must be extracted to eliminate the cause of the pain and/or infection.

RISK OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetic agents and dental injections. These complications may include any or some of the following: pain; swelling; post treatment infection; swelling; bleeding; tooth sensitivity; numbness of the lip, teeth, tongue, chin, gum tissue, cheeks; reactions to injections, changes in occlusion (biting); muscle cramps and spasms; temporomandibular joint (jaw) difficulty; loosening of teeth or tooth restorations; injuries(abrasions, lacerations, cracking, traumatic burns) to other structures in the mouth (cheeks, lips, tongue); referred pain to the ear, neck or head; nausea; vomiting; allergic reactions; itchiness; bruises; delayed healing; and sinus complications. I understand it is my responsibility to report any symptoms to the dentist or member of the dental team immediately. Medication prescribed and drugs administered may cause drowsiness and lack of awareness, concentration, and/or coordination (which may be influenced or potentiated by the use of alcohol and other drugs), thus it is not advisable to operate any vehicle, fast moving equipment, or hazardous device. It may be in your best interest to forego work until fully recovered from any drug effect.

Whenever you have a dental problem your choices can include: no treatment; waiting for more definite development of symptoms to assist in accurate diagnosis, trying to restore the tooth with some sort of filling material or having the tooth removed. Risks involved in these choices might include pain; swelling; infection; tooth loss, and spread of infection to other areas of the head and neck. Since success cannot be guaranteed, treatment will be done in a manner to minimize or avoid risks.

We will gladly explain all treatment we propose to you.
Feel free to ask the dental team any questions that will help you make an informed decision.

Patient (Parent/Guardian) Signature: ___________________________________ Date: ____________________

Next page please

@DENTAL
1701 Green Valley Parkway, Suite 4D
Henderson, NV 89074

FINANCIAL POLICY

This dental practice is a business. We provide dental services in exchange for payment, either directly from the patient or from the many insurance plans we accept. We accept cash, personal check with proper ID, VISA, MasterCard, American Express, and Discover credit cards. We offer 3rd party financing through CareCredit.

- If you have dental insurance:
- **Insurance coverage is a benefit provided by some employers. Most insurance can be used up quickly if extensive dental work is needed. Our office works hard to maximize the dental benefits for each patient, yet we are not insurance experts.. All insurance co-pays quoted and/or collected are an *ESTIMATE*. We try to estimate the correct insurance benefit for any services provided to the best of our ability. We remind you that you the patient are ultimately responsible for any charges not covered by your insurance company. If you have questions regarding a specific planned treatment you should contact your insurance carrier.**
  1. Patient's co-payment is expected at time of service. We can seek predetermination from your carrier, however that is no guarantee of payment from your insurance company.
  2. If your insurance delays paying a valid claim 60 days from the date of service, we will expect you to pay the balance in full. You can then seek reimbursement from your carrier.

- Some dental plans available are simply discount plans. These plans allow the patient to receive dental care at a discounted price for the treatment given. Patients pay the entire amount; there is no insurance support. Payment is due at time of service. Since the dental fee is already discounted, no other discounts apply.

- **Option: You may elect to leave a credit card on file to settle any outstanding balance on your account. If you wish to elect that option, please initial here _______________**

- We expect an adult parent/guardian to accompany and remain in the office when any patient, under 18 years of age, is receiving treatment. We also expect the parent or guardian who brought the patient to our office to pay for the services provided.

- Penalties:
  1. A bounced check is a felony in this state. A **$25 fee** will be charged for any returned check for non-sufficient funds (NSF). Additionally, a copy of the check will be sent to the Clark County District Attorney for action.
  2. After 60 days, **a monthly finance charge of 1.5% (18% APR)** will be added to added to any outstanding balance.
  3. Should your account require action by a collection company, the cost of collections and any associated legal fees will be added to your balance (**about an additional 35-45% is added** to the outstanding balance)
  4. **A postage and handling fee of $10.00** will be charged for the any additional statement requested after the initial bill has been mailed (usually 30 days after treatment).
  5. **Each appointment is your reservation with our office for a specific service. If you fail to show, that time cannot be offered to another valuable patient. Therefore, a patient no show/missed appointment fee will be charged if the patient or parent of a minor patient fails to give the office at least 24 hours notice if they cannot not make their appointment. The fee is $50 dollars for each missed appointment.**

- I understand it is my responsibility to advise this office of any changes in the contact information for me or my family.

Patient Name:____ Date: ___________________________

Parent or Responsible Party: ______________________________ Relationship to Patient: ___________________

Responsible Party Signature:_____________________________________

IF YOU WISH TO LEAVE A CREDIT CARD ON FILE PLEASE FILL OUT INFORMATION BELOW:
Card Type: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Credit Card Number: ______________________________________ Expiration Date: _______________________

Authorizing Signature: _____________________________________ (we will always contact you prior to charging your card)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have a right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _______ day of _______, 20___

Printed Patient Name: ___________________________________

Relationship to Patient: __________________________________

Signature: ____

@ DENTAL
JOSEPH A. WINEMAN, DMD,PC
1701 GREEN VALLEY PARKWAY, SUITE 4D
HENDERSON, NV 89074