Welcome

WINEMAN 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

WINEMAN 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……	☐	☐
Any Joint Replacement……	☐	☐
Location_____		
Hepatitis……	☐	☐
Circle type: A B C		
Blood Thinners?.....	☐	☐
Cancer	☐	☐
Radiation treatment……..	☐	☐
Liver disease……	☐	☐
Kidney diseases……	☐	☐
Fainting/Seizures ……..	☐	☐
Stomach problems……	☐	☐
GERD……	☐	☐
Thyroid problems……..	☐	☐
Diabetes Type _____ …..	☐	☐
AIDS/HIV Infection ……	☐	☐
STD ……	☐	☐

WINEMAN 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

WINEMAN 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

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

FINANCIAL POLICY

PLEASE READ CAREFULLY AND PRINT AND SIGN THE BOTTOM

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, all major credit cards. We offer 3rd party financing through CareCredit.

- If you have dental insurance:
  1. We remind our patients that insurance coverage is a benefit provided by their employers. Our office works hard to maximize the dental benefits for each patient, yet we are not insurance experts. We can only **ESTIMATE** the insurance benefit for any service provided. **WE DO NOT GUARANTEE ANY COVERAGE**.
  2. If you have questions each patient should contact your insurance carrier. Most insurance plans' support can be used quickly if extensive dental work is needed. We remind you that you the patient are ultimately responsible for any charges not covered by your insurance company. Patient's must tell our office if any changes in coverage occur.
  3. 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.
  4. 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.

  INITIAL HERE:_____

  If you have a discount plan: This is not traditional insurance, it simply allows you, the patient, to receive dental care at a discounted price for the treatment given. Patient pays IN FULL at TIME OF SERVICE. Since the dental fee is already discounted, no other discounts apply. INITIAL HERE:_____

- We expect an adult parent/guardian to be present when any patient is under 18 years of age. We also expect the parent or guardian who brought the patient to our office to pay for the services provided. INITIAL HERE:_____

- 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 You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts
  4. **A postage and handling fee of $10.00** will be charged for the any additional statement(s) 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/$100 dollars for each missed appointment as per our appointment policy.**

- I understand it is **my** responsibility to advise this office **of any changes** in the contact information for my family or me. Patient assumes all responsibility for outstanding charges when they fail to update contact information.

  INITIAL HERE: _____

Patient Name:_____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

- **Option: You may elect to leave a credit card on file to settle any outstanding balance on your account.**

Credit Card Number: _____ Expiration Date: _____ CVV:_____

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: _____

Person(s) we are authorized to discuss billing, treatment and appointment information :

_____

_____

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

WINEMAN DENTAL

1701 Green Valley Parkway, Suite 4D
Henderson, NV 89074
702-270-4800

APPOINTMENT POLICY

Each appointment is your reservation with our office for a specific service. If you fail to cancel or show up to your appointment, that time cannot be offered to another valuable patient.
It is a courtesy that we call a week prior to your appointment to remind you. You choose your own appointment times and are expected to show up at the times that you have scheduled. Our office prides itself on running on schedule, please be respectful of other patients time by being punctual for your appointments. Should you present late to your appointment you may be rescheduled and a fee may apply.

If you fail to cancel or show up to your appointment, 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 ONE BUSINESS DAY'S notice if they cannot not make their appointment.

The fee is $50 dollars for each hygiene visit and $100 for a missed appointment with Dr. Wineman.

I understand it is my responsibility to advise this office of any changes in the contact information (Telephone numbers (home, work and cell), mailing address and email) for me or my family.

Patient Signature:_____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

WINEMAN DENTAL

1701 N GREEN VALLEY PARKWAY SUITE 4-D

HENDERSON, NV 89074

702-270-4800

COLLECTIONS PROCEDURES

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). Every effort is made by our office to coordinate benefits and obtain payment by your insurance. Ultimately, you (the patient or guarantor) are responsible for payment for all services rendered. **You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.** If payment is not made in full within 90 days of services (**unless otherwise agreed upon with a signed financial agreement**) the account will be sent to either Plus Four Collections Inc. or IC Systems or any other company hired to complete this task.

In accordance with the Fair Debt Collections Practices Act, you agree, for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account. This includes wireless telephone numbers that may result in charges to you. We may also contact you by sending text messages or emails using the information you provided to us. Methods of contact may include using pre-recorded messages and/or automated dialing service.

I have read this disclosure and agree that WINEMAN DENTAL or their agents may contact me as described above.

Patient Name:_____

Patient Signature: _____ Date:_____

STOP BANG Questionnaire

NAME_____ DATE_____

Height_____ Weight_____ Age _____

M or F BMI_____ Neck Size _____

Please review and Circle your answers.

Do you snore loudly? Louder than talking, or loud enough through closed doors.	YES	NO
Do you often feel tired, fatigued, or sleepy during the day time?	YES	NO
Has anyone observed you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood pressure?	YES	NO
Are diabetic or pre-diabetic?	YES	NO