NEW PATIENT REGISTRATION
Personal Information

Name_____ Sex: M / F
first *middle initial* *last*

Address_____
street *city* *zip*

Age_____ Birth Date_____ Phone_____
home *cell* *e-mail*

Employer_____
name *address* *zip*

Job Title_____ Work Phone_____

Person Financially Responsible (if different than above) _____ Soc. Sec #_____

Address_____
street *city* *zip*

Relation_____Home Phone_____ Work Phone_____

In Case of Emergency, please notify:_____ Phone_____

Insurance Information

Do you have **DENTAL** Insurance? Yes / No If Yes, Answer the Following:

Employer Providing Insurance_____
name *address* *city* *zip*

Insurance Company_____ Group #_____

Insurance Company Address_____

Policyholder's Name_____ Relation to Policyholder? Self / Spouse / Child

Soc. Sec # _____--_____--_____ or Alternate Insurance Issued ID #_____

Policyholder's Birth Date_____

Are you covered by **TWO DENTAL** Insurance Policies? Yes / No

Employer Providing Second Insurance_____
name *address* *city* *zip*

Secondary Insurance Company_____Group #_____

Secondary Insurance Address_____

Secondary Policyholder's Name_____ Relation Self / Spouse / Child

Soc. Sec # _____--_____--_____ or Alternate Insurance Issued ID #_____

Secondary Policyholder's Birth Date_____

Dental Information

Who Referred You to Our Office? _____

Have you had previous Periodontal Treatment? Yes / No When and By Whom? _____

Confidential Medical History

Do you smoke? Yes / No If yes, how much?_____

Have you been examined by a physician within the last year? Yes / No

Are you currently under the care of a physician for any medical condition? Yes / No If yes, please explain _____

_____

Who is your Physician_____ Address_____

Have you ever been hospitalized or had a major operation? Yes / No If yes, please list_____

_____

Are you presently taking any medications or drugs? Yes / No If yes, what are you are taking _____

_____

Are you taking blood thinners such as Coumadin, Heparin, Plavix, Aspirin or Ibuprofen? Yes / No

Are you allergic to any medicine, drug, or other substance? Yes / No If yes, please list _____

_____

Do you have a medical condition that requires an antibiotic pre-medication prior to dental treatment? Yes / No

Have you ever experienced an unusual reaction to local anesthetic (Novocaine or Lidocaine)? Yes / No

Have you ever received radiation therapy of the head and/or neck? Yes / No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

If Yes, list_____

Is there any other information that we should know about your health? Yes / No If yes, please explain _____

_____

If Female, Are you or are you trying to become pregnant? Yes / No If pregnant, how many weeks?_____

Are you nursing? Yes / No Are you using oral contraceptives? Yes / No

Circle any of the following which you have had or have at present:

AIDS/HIV Positive	High Cholesterol	Heart Murmur	Psychiatric Care
Alzheimer's Disease	Chest Pains (Angina)	Heart Pace Maker	Radiation Treatments
Anemia or Hemophilia	Cold Sores/Fever Blisters	Heart Trouble/Disease	Rheumatic Fever
Alcoholism/Drug Addiction	Congenital Heart Disorder	Hemophilia	Shingles
Angina	Cortisone Medicine	Hepatitis A (infectious)	Sickle Cell Disease/Trait
Arthritis or Rheumatism	Diabetes	Hepatitis B or C	Sinus Trouble
Artificial Heart Valve	Emphysema	Herpes	Stomach/Intestinal Disease
Artificial Joint	Epilepsy or Seizures	High Blood Pressure	Stroke
Asthma or Hay Fever	Excessive Bleeding	Hives or Rash	Swelling of Limbs
Blood Transfusion	Fainting Spells/Dizziness	Leukemia	Thyroid Disease
Breathing Problem	Frequent Headaches	Liver Disease	Tuberculosis
Bruise Easily	Genital Herpes	Lung Disease	Ulcers
Cancer or Tumors	Glaucoma	Mitral Valve Prolapse	Vertigo
Chemotherapy	Heart Attack/Failure	Pain in Jaw Joints (TMJ)	Yellow Jaundice

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

Office Policy and Financial Agreement

For the convenience of our patients, the following office policy and financial agreement has been established. In fairness to all, no exceptions are permissible.

FINANCIAL OPTIONS

Accepted payment methods are: Check, Cash, Visa, Master Card, Discover and American Express. We also have a 6 and 12 month interest free payment program through **Care Credit**, a healthcare financing company. If you require longer than 12 months, Care Credit offers low interest payment options up to 60 months. We cannot extend payments in our practice over 90 days.

ACCOUNT BALANCES OVER 90 DAYS

Statements reflecting a balance of $ 3.00 or more will be sent each month, balance is due upon receipt. Finance charges will be applied to accounts that are aged 90 days after the date of service. Accounts over 120 days will be submitted to a collection provider if no previous financial arrangements have been made. If the account is turned over for advanced collection services, the patient or responsible party will be expected to pay all collection fees, court costs, and reasonable attorney fees.

DELTA DENTAL PATIENTS: Please be aware that *some* Delta Dental plans will be issuing the payment to the patient vs. to our office. **You may endorse the Delta Dental check and forward to our office OR you may pay at the time of you appointment, then keep the insurance check for your reimbursement** Please do not overlook any correspondence from Delta Dental as payment may be enclosed.

CANCELLATIONS

As a courtesy to all patients we ask that a 2 business days' notice be given for a cancelled appointment. If we have not received sufficient notice, a charge will be applied to your account.

Release of Information

The undersigned has read the above and agrees, whether he/she signs as responsible party or as patient, to pay the account of Kurt D VanWinkle, DDS, MSD, PC in full **without regard to insurance coverage**. The undersigned further agrees to assign any/all insurance benefits be paid directly to Kurt D VanWinkle, DDS, MSD, PC and agrees to release any information requested by the insurance carrier.

_____ _____

Signature of patient or legal guardian Date

Revised 4/2022

Kurt D. Van Winkle, D.D.S., M.S.D., P.C.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____Telephone:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. A copy of the Privacy Practices is available in our waiting area for your review. If you would like to obtain a copy, one is available upon request. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Kurt D. Van Winkle, D.D.S., M.S.D., P.C., 8902 N. Meridian St. STE 138 Indianapolis, IN 46260 317-844-2792

SIGNATURE

I, _____, understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Signature_____Date:_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will ***not*** affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____

COMPLIMENTARY INSURANCE BENEFITS SERVICE

Please note we are out of network for all insurance companies.

As a courtesy for our patients, we are happy to assist you in filing insurance claims and the necessary diagnostic paperwork for you. All claims and pre-treatment estimates are submitted electronically. It is the insured's responsibility to provide correct filing information on or before their initial visit. We can file to all carriers and receive payments from most. If you are concerned you may not have coverage for an out of network provider, please contact your insurance carrier to confirm you are eligible to be seen in our office. We are not a Medicaid, Healthy Indiana Plan (HIP) or Hoosier Healthwise provider; these particular carriers do not make any payment to our office. We also do not honor any discount plans/programs.

Dental insurance will not pay 100% of all charges, whether in or out of network, so we encourage you to be familiar with your insurance benefits. In some circumstances, you may not be eligible for any benefits payable to our practice, leaving you responsible for the entire fee for services provided.

With thousands of different insurance policies, it is hard to predict exactly what portion you will be responsible for. Before any treatment is performed, we submit a pre-treatment estimate to your carrier to get an approximation of what you would owe. Please know that this will only be an estimate from the insurance and **not** a guarantee of payment.

The maximum time allowed for an insurance claim to be paid is **60** days. After 60 days, the policy holder/patient is responsible for the entire balance. Our office will not accept responsibility for collecting your outstanding claims or for negotiating a settlement on a disputed claim.

DELTA DENTAL PATIENTS: Please be aware that *some* Delta Dental plans will be issuing the payment to the patient vs. to our office. **You may endorse the Delta Dental check and forward to our office OR you may pay at the time of you appointment, then keep the insurance check for your reimbursement** Please do not overlook any correspondence from Delta Dental as payment may be enclosed.

_____ _____

Signature of patient or legal guardian Date