## NEW PATIENT REGISTRATION Personal Information

Name			Sex: M / F
first	middle initial	last	
Addressstreet	city		zip
			zip
Age Birth Date	Phone	cell	e-mail
Employer			
name	address		zip
Job Title		Work Phone	
Person Financially Responsible (if d	different than above)	Soc. Sec #	
Address			
street	city		zip
Relation	Home Phone	Work	r Phone
In Case of Emergency, please notify	y:	Phone	
	Insurance Info	rmation	
Do you have <b><u>DENTAL</u></b> Insurance?	Yes / No If Yes, Answer th	e Following:	
Employer Providing Insurance			
	name address	city	zip
Insurance Company		Group #	
Insurance Company Address			
Policyholder's Name		Relation to Policyholo	der? Self / Spouse / Child
Soc. Sec #	or Alternate Insurance Iss	ued ID #	
Policyholder's Birth Date			
Are you covered by <b>TWO DENTA</b>	L Insurance Policies? Yes / No		
Employer Providing Second Insura:	nce		
	name	address city	zip
Secondary Insurance Company		Group #	
Secondary Insurance Address			
Secondary Policyholder's Name		Relation S	elf / Spouse / Child
Soc. Sec #	or Alternate Insurance Iss	ued ID #	
Secondary Policyholder's Birth Dat	te		
	Dental Inforn	nation	
Who Referred You to Our Office?			

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

### **Confidential Medical History**

cheimer's Disease Chest Pains (Angina) Heart Pace Maker Radiation Treatments  emia or Hemophilia Cold Sores/Fever Blisters Heart Trouble/Disease Rheumatic Fever  coholism/Drug Addiction Congenital Heart Disorder Hemophilia Shingles  gina Cortisone Medicine Hepatitis A (infectious) Sickle Cell Disease/Trait  chritis or Rheumatism Diabetes Hepatitis B or C Sinus Trouble  difficial Heart Valve Emphysema Herpes Stomach/Intestinal Disease  chima or Hay Fever Excessive Bleeding Hives or Rash Swelling of Limbs  chathing Problem Frequent Headaches Liver Disease Tuberculosis  difficial Herpes Ulcers  difficial Herpes Glaucoma Mitral Valve Prolapse  difficial Fever Waddiction Congenital Heart Pace Maker Radiation Treatments  Rheumatic Fever  Shingles  Sickle Cell Disease/Trait  Sinus Trouble  Stroke  Stroke  Swelling of Limbs  Thyroid Disease  Tuberculosis  Ulcers  Ulcers  Glaucoma Mitral Valve Prolapse  Wertigo  Yerligo  Yellow Jaundice	Do you smoke? Yes / No	If yes, how much?		
Who is your Physician	Have you been examined b	by a physician within the last year	r? Yes / No	
Have you ever been hospitalized or had a major operation? Yes / No	Are you currently under th	e care of a physician for any med	dical condition? Yes / No If y	es, please explain
Are you presently taking any medications or drugs? Yes / No If yes, what are you are taking	Who is your Physician		Address	
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	Have you ever been hospit	alized or had a major operation?	Yes / No If yes, please list	
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  What is your preferred Pharmacy? Name/Address/Phone  If Female. Are you or are you trying to become pregnant? Yes / No If pregnant, how many weeks?  Are you oursing? Yes / No Are you using oral contraceptives? Yes / No  Circle any of the following which you have had or have at present:  DS/HIV Positive High Cholesterol Heart Murmur Psychiatric Care theimer's Disease Chest Pains (Angina) Heart Pace Maker Radiation Treatments emia or Hemophilia Cold Sores/Fever Blisters Congenital Heart Disorder Hemophilia Shingles  Diabetes Congenital Heart Disorder Hepatitis B or C Sins Trouble ificial Joint Epilepsy or Seizures High Blood Pressure High Blood Pressure High Blood Pressure High Blood Pressure Excessive Bleeding Hives or Rash Swelling of Limbs Thyroid Disease Thyroid Disease Ulcers Ung Disease Ulcers Vertigo Tumors Glaucoma Mitral Valve Prolapse Vertigo  Mitral Valve Prolapse Vertigo  What is you aver experienced an unusual reaction to local anesthetic (Novocaine or Lidocaine)? Yes / No  Have you ever experienced an unusual reaction to local anesthetic (Novocaine or Lidocaine)? Yes / No  Have you ever experienced an unusual reaction to local anesthetic (Novocaine or Lidocaine)? Yes / No  Have you ever texel and do not have at present and prove yes / No  If yes / No  If yes / No  Have you ever texel and do not have at present and yes / No  If ye	Are you presently taking a	ny medications or drugs? Yes / I	No If yes, what are you are tak	ing
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  What is your preferred Pharmacy? Name/Address/Phone  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:  DS/HIV Positive  High Cholesterol  Heart Murmur  Psychiatric Care cheimer's Disease  Chest Pains (Angina)  Heart Pace Maker  Radiation Treatments  emia or Hemophilia  Cold Sores/Fever Blisters  Heart Trouble/Disease  Chemophilia  Congenital Heart Disorder  Hepatitis A (infectious)  Sickle Cell Disease/Trait  hritis or Rheumatism  Diabetes  Hepatitis B or C  Sinus Trouble  Stroke  stroke  stroke  stroke  stroke  thma or Hay Fever  Excessive Bleeding  Hives or Rash  Swelling of Limbs  Thyroid Disease  Thyroid Disease  Thyroid Disease  Thyroid Disease  There of Tumors  Glaucoma  Mitral Valve Prolapse  Wertigo  Yesl / No  If yes, / N	Are you taking blood thin	nners such as Coumadin, Hepa	rin, Plavix, Aspirin or Ibupro	fen? 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  What is your preferred Pharmacy? Name/Address/Phone  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:  DS/HIV Positive  High Cholesterol Heart Murmur Psychiatric Care chethemer's Disease  Chest Pains (Angina) Heart Radiation Treatments emia or Hemophilia Cold Sores/Fever Blisters Heart Trouble/Disease Rheumatic Fever Soholism/Drug Addiction Congenital Heart Disorder Hemophilia Shingles (Congenital Heart Disorder Hepatitis A (infectious) Sickle Cell Disease/Trait hritis or Rheumatism Diabetes Hepatitis B or C Sinus Trouble ifficial Joint Epilepsy or Seizures High Blood Pressure Stroke chma or Hay Fever Excessive Bleeding Hives or Rash Swelling of Limbs or Tansfusion Fainting Spells/Dizziness Leukemia Thyroid Disease Tuberculosis use Easily Genital Herpes Lung Disease Ulcers verigo emotherapy Heart Attack/Failure Pain in Jaw Joints (TMJ) Yellow Jaundice	Are you allergic to any m	edicine, drug, or other substan	ace? Yes / No If yes, please list	i
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  What is your preferred Pharmacy? Name/Address/Phone  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:  DS/HIV Positive High Cholesterol Heart Murmur Psychiatric Care Radiation Treatments Phemia or Hemophilia Cold Sores/Fever Blisters Heart Trouble/Disease Rheumatic Fever Congenital Heart Disorder Hemophilia Shingles gina Cortisone Medicine Hepatitis A (infectious) Sickle Cell Disease/Trait Shritis or Rheumatism Diabetes Hepatitis B or C Sinus Trouble hritis or Rheumatism Diabetes Hepatitis B or C Sinus Trouble of Transfusion Fainting Spells/Dizziness Leukemia Thyroid Disease Stroke Problem Frequent Headaches Liver Disease Tuberculosis uise Easily Genital Herps Lung Disease Ulcers Nertly of Pain in Jaw Joints (TMJ) Yellow Jaundice	Do you have a medical con	ndition that requires an antibiotic	pre-medication prior to dental t	reatment? Yes / No
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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:  DS/HIV Positive High Cholesterol Heart Murmur Psychiatric Care theimer's Disease Chest Pains (Angina) Heart Pace Maker Radiation Treatments emia or Hemophilia Cold Sores/Fever Blisters Heart Trouble/Disease Rheumatic Fever scholism/Drug Addiction Congenital Heart Disorder Hemophilia Shingles gina Cortisone Medicine Hepatitis A (infectious) Sickle Cell Disease/Trait hritis or Rheumatism Diabetes Hepatitis B or C Sinus Trouble ifficial Heart Valve Emphysema Herpes Stomach/Intestinal Disease ifficial Joint Epilepsy or Seizures High Blood Pressure Stroke thma or Hay Fever Excessive Bleeding Hives or Rash Swelling of Limbs and Transfusion Fainting Spells/Dizziness Leukemia Thyroid Disease tashing Problem Frequent Headaches Liver Disease Tuberculosis the Easily Genital Herpes Lung Disease Vertigo Pain in Jaw Joints (TMJ) Yellow Jaundice	Is there any other information	ion that we should know about y	our health? Yes / No If yes, ple	ease explain
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:  DS/HIV Positive High Cholesterol Heart Murmur Psychiatric Care theimer's Disease Chest Pains (Angina) Heart Pace Maker Radiation Treatments Pemia or Hemophilia Cold Sores/Fever Blisters Heart Trouble/Disease Rheumatic Fever Scholism/Drug Addiction Congenital Heart Disorder Hemophilia Shingles Sickle Cell Disease/Trait Phritis or Rheumatism Diabetes Hepatitis A (infectious) Sickle Cell Disease/Trait Phritis or Rheumatism Diabetes Herpes Stomach/Intestinal Disease Problem Epilepsy or Seizures High Blood Pressure Stroke Phina or Hay Fever Excessive Bleeding Hives or Rash Swelling of Limbs Problem Frequent Headaches Liver Disease Tuberculosis Problem Frequent Headaches Liver Disease Tuberculosis Problem Glaucoma Mitral Valve Prolapse Pain in Jaw Joints (TMJ) Yellow Jaundice	What is your preferred Pha	rmacy? Name/Address/Phone		
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he best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect infor				

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_\_ DATE\_\_\_\_\_

# Kurt D. Van Winkle, D.D.S., M.S.D., P.C. David R. Van Winkle, D.D.S., M.S.D. 8902 N. Meridian Street, Suite 138, Indianapolis, IN 46260 (317) 844-2792 DWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION	A: PATIENT GIVING CONSENT		
Name:		Date:	
Address: _	······································	Telephone	:
SECTION	B: TO THE PATIENT - PLEASE READ TH	E FOLLOWING STATEMENTS CA	REFULLY.
be shared	Notice of Privacy Practices, should I choos with my referring dental office, my insurance der to carry out treatment, payment activitie	e company (if applicable), my prefer	n to read and/or obtain a copy of d Health Information (PHI) will red pharmacy, and anyone I list
SECTION	C: CONTACT INFORMATION FOR PROTI	ECTED HEALTH INFORMATION (	PHI)
You may d	isclose my Protected Health Information (PI	HI) to my family members and/or no	n-family members listed below:
NAME		PHONE NUMBER	RELATIONSHIP
PERT	AINING TO APPOINTMENT REMINDERS/ PLEASE CH	CONFIRMATIONS AND OTHER C	FFICE COMMUNICATION,
	u may leave a voicemail		
	u may send a text message		
□ Yo	u may send an email. Email:	· · · · · · · · · · · · · · · · · · ·	
Print Name	e:	Date	
Signature:	(Parent or Guardian signature if minor)		·

YOU ARE ENTITLED 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 of 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.

Data	
Date.	
	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.

**<u>DELTA DENTAL PATIENTS</u>**: Please be aware that *some* Delta Dental plans may be issuing the payment to the patient instead of to our office. \*\*You may endorse the Delta Dental check and forward it to our office OR you may pay at the time of your appointment and 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 notice of 2 business days 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. Van Winkle, D.D.S., M.S.D., P.C. in full without regard to insurance coverage. The
undersigned further agrees to assign any/all insurance benefits to be paid directly to Kurt D. Van Winkle,
D.D.S., M.S.D., P.C. and agrees to release any information requested by the insurance carrier.

Signature of patient or legal guardian	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), Hoosier Healthwise, or HMO/DMO provider; these particular carriers do not make any payment to our office. We also do not honor any discount plans/programs.

Dental insurance will <u>not</u> 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. If time allows before 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.

<u>DELTA DENTAL PATIENTS</u>: Please be aware that *some* Delta Dental plans may be issuing the payment to the patient instead of to our office. \*\*You may endorse the Delta Dental check and forward it to our office OR you may pay at the time of your appointment and 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