

# Welcome Angela S. Wingate, DDS, PA

Welcome To Our Practice!

Our entire dental team is committed to providing you with the highest standard of personalized dental care in a positive, warm, efficient, and professional manner. We are confident that our exceptional skills, friendly atmosphere, and comfortable accommodations will make you delighted that you have joined our growing family of patients. If there are ever any suggestions on how we may improve your visit, feel free to let us know.

In our efforts to maintain high standards of care, we stress the importance of honoring your scheduled appointment. We understand that unforeseen emergencies may arise. It is our office policy that you give us at least 24 hours advanced notice if you ever need to cancel or reschedule an appointment. For patients that fail to come to their scheduled appointment, or have cancelled within 24 hours of their appointment, a \$40.00 fee will be charged to your account.

Our office hours are Mon- Thu. from 7:30 am - 4:00 pm. Because emergencies arise, we ask that a parent or guardian remain in the waiting area during the entire dental visit of their child under the age of 18.

**We respectfully request that you please refrain from cell phone use in clinical rooms.**

## PATIENT INFORMATION

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	<b>Marital status</b> (circle one) Single / Mar / Div / Sep / Wid	<b>Birth Date:</b> / /	<b>Age:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>SSN:</b>
<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.					

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

P.O. Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

**How did you find our office?** (Please check one box.)

Dr.     Insurance Plan     Family/Friend     Internet     Close to home/work     Yellow Pages     Other

## INSURANCE INFORMATION

**Is this patient covered by:** Insurance?    **yes**    **no**                      Discount Plan?    **yes**    **no**

\*\* If you have any questions about your dental coverage, please review with your employer's benefit administrator.

Patient's relationship to subscriber: \_\_\_\_\_

Subscribers Name \_\_\_\_\_

Subscriber's Home Address: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ Member/ Policy # \_\_\_\_\_

### INSURANCE ASSIGNMENT:

I authorize and request my insurance company to pay directly to the dentist or dental group my insurance benefits that would otherwise be 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 for my dependents.

**Patient (or Parent's) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**EMERGENCY:**

Person to contact in case of emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**DENTAL HISTORY:**

Former Dentist: \_\_\_\_\_ Last Visit: \_\_\_\_\_ Date of Last Dental X-rays: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Use Mouthwash? \_\_\_\_\_

Please check any of the following conditions that apply to you:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Bad Breath         | <input type="checkbox"/> Grinding of Teeth       | <input type="checkbox"/> Periodontal (Gum) Disease      | <input type="checkbox"/> Bleeding Gums            |
| <input type="checkbox"/> Mouth Sores        | <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity when Chewing |
| <input type="checkbox"/> Sensitivity to Hot | <input type="checkbox"/> Sensitivity to Cold     | <input type="checkbox"/> Food Collects Between Teeth    | <input type="checkbox"/> Sensitivity when Biting  |

	YES	NO	COMMENTS
Have you ever had a reaction to anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke? How Much? _____ Packs per day	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you chew tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>	WHEN: _____

If it has been more than 1 year since your last dental visit, what kept you from going to the dentist?  
\_\_\_\_\_

**MEDICAL HISTORY:**

Physician: \_\_\_\_\_ Physician Telephone: \_\_\_\_\_

**Are you allergic to any of the following?**

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  No Known Allergies  Other: \_\_\_\_\_

Please list all medications you are currently taking (Including vitamins, over the counter medicine and natural supplements):  
\_\_\_\_\_

Do you pre-medicate with antibiotics prior to your dental appointments?  YES  NO If so, please contact us prior to your appointment.

**WOMEN ONLY:**

Are you pregnant  YES  NO Nursing  YES  NO Taking Birth Control Pills  YES  NO

**ALL PATIENTS:**

**Do you have a history of the following?**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Heart Problems*         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> Artificial Heart Valve* |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Rheumatic Fever*      | <input type="checkbox"/> Mitral Valve Prolapse*  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Heart Pace Maker        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Cough, Persistent     | <input type="checkbox"/> Heart Murmur*           |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> HIV Positive / AIDS  | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Cough up Blood          |
|  |   | <input type="checkbox"/> Convulsions           | <input type="checkbox"/> Headaches               |
- \* Conditions may require pre-medication with antibiotics

Current Health Conditions: \_\_\_\_\_

**AUTHORIZATION:**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to my child or me during the period of such dental care to third party payers and/or health insurance practitioners.

**Patient (or Parent's) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Angela S. Wingate, D.D.S., P.A.*

*210 New Fidelity Court*

*Garner, NC 27529*

*P: (919) 329-0140 F: (919) 329-0740*

## **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgment\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature of Patient, Parent or Guardian)

\_\_\_\_\_  
(Date)

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### **For Office Use Only**

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We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgment
  - An emergency situation prevented us from obtaining acknowledgment
  - Other (Please Specify)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

