Michael Wainscott DDS

4419 N. HWY 7, Suite 301 Hot Springs Village, Ar 71909 501-984-6400

Welcome to Wainscott Family Dental. In order to serve you better, please read our office policies and procedures.

INSURANCE: We will file your primary and secondary insurance as a courtesy. However, if your insurance company does NOT remit payment within 45 days, the balance will be due in full from you. Since we are not the party to the agreement with your insurance carrier, it is not our responsibility to contact them to establish why they have not paid, or why they paid less than originally indicated.

<u>BILLING:</u> Regardless of your dental insurance, **our office relies on you to settle your account.** It is your responsibility to pay any deductible, co-insurance, and co-pays at the time of service and any other balance left unpaid by your insurance company.

<u>COLLECTIONS</u>: If your account is turned over to our collection service the physician/patient relationship will be terminated. We will provide 30 days of "emergency only" care, which must be paid in full at the time of service.

PRESCRIPTION REFILLS: We require 48 hours for prescription refills.

CANCELLATION: We request you cancel your appointment within 24 hours or before so the appointment time. If you have three or more no show appointments or cancellations with less than 24 hours notice, our office has the right to terminate the doctor/patient relationship.

By signing below, I have read and fully understand the above policies and agree to abide by each of them.

Patient Name:	Date:		
Signature:			

Michael Wainscott DDS 4419 N. HWY 7, Suite 301 Hot Springs Village, AR 71909 5019846400

NAME
Thank you for visiting our office! We're glad you're hereGetting to know you-
1. Why did you select our office?
2. Whom may we thank for referring you?
3. Is another member of your family a patient here? Who?
4. Who is your emergency contact? Name Relation Phone #
5. When was your last dental visit?
6. When was the last time you had complete dental x-rays taken? Where?
7. How do you feel about the appearance of your teeth?

8. If you could change anything about your smile, what would you

change?

PATIENT REGISTRATION

ID:	Chart ID:	
First Name:	Last Name:	Middle Initial:
Patient Is: Policy He	Holder Responsible Party Preferred Name:	
Responsible Party ((if someone other than the patient)	···
First Name:	Last Name:	Middle Initial:
Address:	Address 2:	
City, State, Zip:	rentant de la companya del companya della companya	ager:
Home Phone:	Work Phone: Ext: Cel	lular:
Birth Date:	Soc Sec: Drivers Lie:	
Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder		
Patient Information	1	
Address:	Address 2:	
City:	State / Zip:	ager:
Home	Work Phone: Ext: Cell	
Phone:	• Company of the comp	
Sex: Male		Widowed
Birth Date:	Age: Soc Sec: Drivers Lic:	
E-mail:	☐ I would like to receive correspondences via e-mail.	
Employment Ful	Section 2 Section 3	
Student Status: Ful	ill Time Part Time	
Medicaid ID:	Pref. Dentist:	·
Employer ID:	Pref. Pharmacy:	
Carrier ID:	Pref. Hyg:	
<u> </u>		·
Primary Insurance In	nformation ————————————————————————————————————	
Name of Insured:	Relationship to Insured: Self Spouse Chi	id Other
Insured Soc. Sec:	Insured Birth Date:	
Employer:	Ins. Company:	
Address:	Address:	
Address 2:	Address 2:	
City, State, Zip:	City, State, Zip:	
Rem. Benefits:	Rem. Deduct:	
icin, Delicitis.		
Secondary Insurance	e Information	
Name of Insured:	Relationship to Insured: Self Spouse Chi	ld Other
Insured Soc. Sec:	Insured Birth Date:	
Employer:	Ins. Company:	
Address:	Address:	
	Address 2:	
Address 2:	City, State, Zip:	
City, State, Zip:	yan yang banan dan kabupatèn kalamatan banan Nababatan Salamatan Kabupatèn Banan Kabupatèn Banan Banan Banan B	
Rem. Benefits:	Rem. Deduct:	

Michael R Wainscott DDS Eaglesoft Medical History Birth Date:

Patient Name:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you under a physician's care now? Yes No If ves Have you ever been hospitalized or had a major Yes No If yes operation? Have you ever had a serious head or neck injury? Yes No If yes Are you taking any medications, pills, or drugs? Yes O No If yes Do you take, or have you taken, Phen-Fen or Redux? Yes <a> No If yes Have you ever taken Fosamax, Boniva, Actonel or Yes
No If yes any other medications containing bisphosphonates? Are you on a special diet? Yes No Do you use tobacco? Yes No Women: Are you... Nursing? Pregnant/Trying to get pregnant? Taking oral contraceptives? Are you allergic to any of the following? Aspirin Penicillin Codeine ☐ Acrylic Metal Sulfa Drugs Local Anesthetics □ Latex Other? If yes Do you use controlled substances? 🦈 Yes 🕾 No If ves Do you have, or have you had, any of the following? Yes ⊕ No. O Yes O No O Yes O No AIDS/HIV Positive Cortisone Medicine Hemophilia **Radiation Treatments** Yes No 🔾 Yes 🔘 No Yes No 🖒 Yes 🖒 No 🗇 Yes 💢 No Alzheimer's Disease Diabetes Hepatitis A Recent Weight Loss YesNo Yes O No Yes No 🔘 Yes 🕒 No Anaphylaxis **Drug Addiction** Hepatitis B or C Renal Dialysis 🕒 Yes 🕘 No O Yes O No Yes No Anemia Easily Winded O Yes O No Rheumatic Fever Herpes Yes Yes Angina 🖒 Yes 🖒 No Yes () No Emphysema High Blood Pressure Rhoumaticm 🖒 Yes 🔆 No Yes O No (i) Yes (i) No Arthritis/Gout Epilepsy or Seizures 🖒 Yes 🕒 No High Cholesterol Scarlet Fever O Yes O No 🗇 Yes 💮 No Artificial Heart Valve 🗘 Yes 🔘 No 🗇 Yes 🕥 No Excessive Bleeding Hives or Rash Shinales O Yes O No Artificial Joint **Excessive Thirst** O Yes O No YesNo 🗇 Yes 🗇 No Hypoglycemia Sickle Cell Disease 🖰 Yes 🔘 No () Yes () No Asthma Fainting Spells/Dizziness 🔘 Yes 🔘 No Yes < No</p> Sinus Trouble Irregular Heartbeat ○ Yes ○ No 🕘 Yes 🔘 No Yes No Yes (*) No Spina Bifida **Blood Disease** Frequent Cough Kidney Problems Stomach/Intestinal Disease 🔘 Yes 🔘 No Yes <a> No Yes No **Blood Transfusion** Frequent Diarrhea Leukemia 💮 Yes 🕘 No Yes No Yes O No 🔘 Yes 💮 No **Breathing Problems** Frequent Headaches Stroke Liver Disease C Yes C No Yes O No Yes
No **Bruise Easily** Genital Herpes Low Blood Pressure Swelling of Limbs ○ Yes ○ No 🗇 Yes 🔘 No Cancer Glaucoma Yes No Lung Disease Yes
No Thyroid Disease Chemotherapy 🔘 Yes 👸 No Hay Fever Yes No Mitral Valve Prolapse 🖒 Yes 🔘 No **Tonsillitis** 💮 Yes 🔘 No ○ Yes ⊙ No 🥶 Yes 💮 No Yes O No 🖰 Yes 🔘 No Heart Attack/Failure Tuberculosis Chest Pains Osteoporosis 🖱 Yes 🔘 No 💮 Yes 💮 No Cold Sores/Fever Blisters 🔿 Yes 🔘 No 🔘 Yes 🔘 No Tumors or Growths Heart Murmur Pain in Jaw Joints 🗇 Yes 🙆 No Yes (No Congenital Heart Disorder 🔘 Yes 🔘 No 🖱 Yes 🖱 No Ulcers Heart Pacemaker Parathyroid Disease 🕘 Yes 🙋 No YesNo Yes <a> No Heart Trouble/Disease 👙 Yes 🖒 No Venereal Disease Convulsions Psychiatric Care Yes < No</p> Yellow Jaundice Have you ever had any serious illness not listed Yes
No Comments:

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:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Such restrictions.
Patient Name:
Relationship to Patient:
Signature:
Date:
OFFICE USE ONLY
I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.
Date: I tribials