CHRISTINE R. WENRICK, DMD, PLLC
1745 MEMORIAL DRIVE
CLARKSVILLE, TN 37043
(931)551-3351

PATIENT REGISTRATION FOR MINORS

Minor's Name:
First Name: _____Last Name: _____Middle Initial: ___
Preferred Name: _____ Sex: □ Male □ Female
Birth Date: _____ Soc. Sec: _____
Emergency Contact:_____ Phone Number:_____

Responsible Party:
First Name: _____Last Name: _____Middle Initial: ___
Relationship to Minor:_____
Address:_____City:_____
State/Zip: _____ Home Phone:_____ Work Phone:_____
Cell Phone: _____ □ Receives Text Messages
E-mail:_____ □ Receives E-mails
Birth Date: _____ Soc. Sec: _____
Driver's License: _____Employer:_____
How did you hear about our office: _____

Primary Insurance Information:
Name of Insured: _____
Relationship to Insured: □ Self □ Spouse □ Child □ Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Insurance Comany:_____ Group Number:_____
Subscriber ID:_____ Employer: _____

Please circle the TWO most important reasons for seeking dental care for your minor:

FUNCTION- the ability to speak and chew properly
COSMETICS- the appearance of your mouth and teeth
HEALTH- control of dental disease
TRUST- reliable, good, and honest dental care

Please circle the TWO reasons that would prevent you from completing necessary dental treatment with your minor:

DISCOMFORT- fear of pain or discomfort during treatment
COST- affordability of necessary dental treatment
SCHEDULING- missing work or school for required dental appointments
INSURANCE- relying on insurance to cover all dental treatment.

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GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and the social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1) ***Drug or chemical reaction.*** *Dental materials and medications may trigger allergic or sensitivity reactions.*
2) ***Long-term numbness (paresthesia).*** *Local anesthetic, or its administration, while most always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.*
3) ***Muscle or joint tenderness.*** *Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.*
4) ***Sensitivity in teeth or gums, infection, or bleeding.***
5) ***Swallowing or inhaling small objects.***

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page: Initials: _____
I give permission to use "before" and "after" photos of my smile: Initials: _____

Minor's Name: _____

Parent's Name:_____

Parent's Signature:_____

Date:_____

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NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. If you have questions regarding our privacy practices please contact:

Office Manager: Kim Freeman
Phone Number: 931-551-3351
Email:crwenrickdmd@bellsouth.net

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

_____ Initials

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

By signing this consent you are aware that our office is HIPPA compliant and we will not release any of your confidential information without your signed authorization.

Minor's Name: _____

Parent's Name:_____

Parent's Signature:_____

Date:_____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I agree to the following by placing my initials next to each number:

1._____I authorize the professional office of my dentist named above to release health information identifying my minor [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services]to the following persons:

Name:_____ Relation:_____

Name:_____ Relation:_____

2._____I authorize this practice to take any necessary radiographs, study models, photos, and other diagnostic aids of my minor as needed to make a thorough diagnosis.

3. _____I authorize photos and radiographs of my minor to be emailed to referring providers and insurance companies.

4. _____I authorize this practice to perform all recommended and agreed upon treatment on my minor.

I recognize that the office of Christine R. Wenrick, DMD, PLLC will rely upon my signing of this document in accepting my minor for evaluation as a patient.

Minor's Printed Name:_____

Parent's Printed Name: _____

Parent's Signature:_____

Date:_____

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GUIDELINE FOR CHILDREN AND MINORS IN OUR OFFICE

Due to the nature of our business and risks there are in a dental office, we ask child care be provided for any young children not scheduled the day of an appointment. All young children in the waiting room must be chaperoned by an adult during the duration of your visit and cannot be left unattended at any point during your visit with us. Children are never permitted in the treatment rooms when not being seen. We appreciate your cooperation in helping us keep your family safe.

We are delighted to have your child/minor as part of our dental practice. We enjoy treating children and we look forward to making the visit pleasant for you and your child. We see children beginning at the age of three.

Three year old children are welcome to be accompanied by one parent/or legal guardian, who will sit in the treatment chair with the three year old on their lap. At the age of four we require your child to be comfortable accompanying our staff through the dental experience, once the examination, cleaning and any x-rays are completed we will invite one parent or legal guardian back to the treatment room to review the results of the day's appointment. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own.

Teenagers under the age of 18 must have a parent/or legal guardian present in the waiting room during the duration of any treatment. Dr. Wenrick will meet with you at the end of an appointment to discuss the dental health of your teenager.

We appreciate the understanding of these guidelines, as the safety and wellness of your family is a primary concern when you visit our office.

Please initial and sign in agreement.

_____ I understand that these guidelines must be met in order to successfully fulfill any appointment that I schedule for myself or any member of my house hold.

_____ If for any reason I am unable to provide childcare for my scheduled appointment I will give a minimum 3 business day notice of my need to reschedule to a day that I am able to provide the necessary child care for a successful dental appointment.

_____ I understand that if the above guidelines are not met that I will be dismissed from my appointment and may be responsible for a broken appointment fee.

Minor's Name: _____

Parent's Name:_____

Parent's Signature:_____ Date:_____

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PERMISSONS FROM LEGAL GAURDIAN

I_____ am the legal guardian of:

Child's Name_____

Child's Name_____

Child's Name_____

Child's Name_____

I grant full permissions to the following persons to care for my children in the case of my absence when concerning any appointment with Dentistry by Christine R. Wenrick DMD, PLLC.

Name of Caregiver_____

Name of Caregiver_____

In addition, in the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Print Name:_____

Signature: _____

Date:_____

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PATIENT AND OFFICE AGREEMENTS

I agree to the following by placing my initials next to each number:

Payment Agreement

1. _____If, for any reason, my insurance company does not pay Dr. Wenrick's office for my minor's dental treatment I agree to pay in full for my dental treatment at the time services are rendered.

2. _____I agree to pay my minor's insurance deductible and estimated patient portion for all dental services. I understand that the dental office manager can only estimate what my minor's insurance coverage will be. I take full responsibility for any remaining balance after my insurance company has paid dental claims. NOTE: On average, insurance companies pay between 52% - 70% of dental treatment.

3. _____While the filing of insurance claims is a courtesy that we extend to our patients we must emphasize that as oral healthcare providers our relationship is with you, the responsible party, and not the insurance company. If this office does not receive dental insurance payment within forty-five(45) days, payment will become my responsibility. The dental office does not accept responsibility for collecting money on denied insurance claims or disputes.

Collection Agreement

4. _____I agree to pay all costs of collection including, but not limited to attorney fees, collection fees, and contingent fees to collection agencies not less than 35%. Such contingent fee will be added and collected by the collection agency immediately upon my default and office's referral of my account to said collection agency. **Returned checks will be charged a $50.00 fee.** I further understand that Christine R. Wenrick, DMD, PLLC reserves the right to terminate our healthcare provider-patient relationship in the event that my account becomes over thirty (30) days delinquent, and impose interest at twenty-four (24%) per annum.

5. _____I understand that if I choose to have my minor's records or x-rays emailed to a different location, I must have a $0.00 account balance and I am required to sign a records release form provided by Dr. Wenrick's office.

Cancellation Agreement

6. _____I understand time is precious for both me and my minor's dental care team. Dr. Wenrick and staff take pride in seeing one patient at a time. I agree to respect their busy schedule and will be prompt with my minor's dental appointments.

7. _____I understand that certain appointments may require a deposit which will be applied to services rendered at that appointment.

8. _____ I understand that I am to notify the office of the need to reschedule my minor's appointment at least **three (3)** business days prior to the scheduled appointment. Failure to notify the office within this time frame may result in the loss of my deposit, or I may be charged for the total appointment fee for the treatment scheduled.

HIPPA Agreement

9. _____I have had the opportunity to read and have access to a copy of this office's Notice of Privacy Practices.

10. _____The undersigned agrees that they have read and understand this entire agreement and have not signed below in reliance upon any verbal or written promise, condition, or representation made by any person.

I recognize that the office of Christine R. Wenrick, DMD, PLLC will rely upon my signing of this document in accepting me for evaluation as a patient.

Minor's Name:_____

Parent's Name: _____

Parent's Signature:_____

Date:_____

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ACID INTAKE REPORT

When acid from food, drink and the stomach come in contact with teeth, the tooth's hard enamel surface can soften. When you then brush your teeth, the softened enamel can be worn away more easily and become thinner over time. This condition is known as acid erosion. The more frequently you consume acidic foods and drinks and the longer they stay in your mouth, the greater your risk of acid erosion.

Item	pH	How often item is consumed
Wine	2.3-3.8	
Sports Drinks	2.3-4.4	
Cola Drinks	2.6	
Citrus Fruit or Beverage	2.8-4.0	
Iced Tea	2.9-3.0	
Strawberries	3.0-4.2	
Vinegar	3.2	
Tomatoes	3.7-4.7	
Honey	3.9	
Seedless Raisins	4.0	
Yogurt	4.2	
Bananas	5.1	
Whole Milk	6.7	
Water	7.3	

The lower the pH, the higher the acidity and therefore the higher the risk that it may cause acid erosion (water is pH neutral).

	Y	N
1. Do you enjoy fruits, salad dressing, or jams throughout the day?	[ ]	[ ]
2. Do you regularly drink juices, teas, wine, sport drinks, and or sodas?	[ ]	[ ]
3. Do you often snack between meals?	[ ]	[ ]
4. Do you brush your teeth soon after eating or drinking?	[ ]	[ ]
5. Do you hold or swish drinks around in your mouth (e.g. Wine)?	[ ]	[ ]
6. Do you experience acid reflux?	[ ]	[ ]
7. Do you eat 1 to 2 hours before bed?	[ ]	[ ]

Did you know sipping on drinks can do more harm than drinking them all at one time, and grazing on acidic foods keeps the oral cavity at a low acidic value, thus causing more damage to the enamel?

You may notice changes in the appearance of your teeth. Teeth may become more yellow in color, translucent at the edges or alternatively may change shape or you may notice small dents on the tooth surface. These are signs of acid erosion.

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CREDIT CARD PAYMENT AUTHORIZATION

NAME:
(AS IT APPEARS ON THE CREDIT CARD)

In order to keep our treatment costs and clerical fees down, we keep a credit or debit card number on file for those patients who choose to pay their *estimated* financial portion for treatment at the time services are rendered instead of paying in full. This credit card number will only be used if there is an outstanding balance on your account not paid by you or your insurance companies within thirty (30) days after services have been rendered. We will be courteous and mail you a receipt along with a copy of your account upon posting these charges. Also, this card number may be used at your convenience for quick and easy payments for future appointments and purchases.

I, the undersigned authorize Christine R. Wenrick, DMD, PLLC to charge my:

( ) Master Card ( ) Visa ( ) Discover ( )Care Credit

Card Number: _____

Expiration Date: _____

Last 3 numbers in Signature Line: _____

Printed Cardholder Name:

Signature of Cardholder:

Today's Date:

Note: Our office "strictly" adheres to all HIPAA and Red Flag Rules. Your cards safety and security will be protected.