Norwood Dental Care
207 W. Wilson Street
Wingate, NC 28174
Phone: 704-233-5545 • Fax: 704-233-9597
www.wingatedentalcare.com

Dr. Jonathan C. Allen, Jr.
Dr. Mark D. Lassiter, Sr.

Welcome to Our Office

Thank you for contacting Wingate Dental Care. We appreciate the opportunity to provide you and your family with a complete and comfortable dental experience. Our staff is made up of qualified professionals who work together as a team to bring you the highest quality of dental care.

Your first visit to our office will include thorough medical and dental histories, a comprehensive dental exam and any radiographs that may need to be taken. We will then discuss our findings and treatment recommendations with you. Be sure to come with any questions or concerns that you may have.

We offer appointment times to accommodate most lifestyles and strive to provide each of our patients with personal attention and excellent results. It is important to realize that your appointment time is reserved especially for you. If the appointment becomes inconvenient for you, please inform us with a 48 hour notice.

In an attempt to use time more efficiently and be better prepared for your examination, we have enclosed a packet of information that we would like for you to complete and bring with you to your appointment date on: **DATE**_____ **TIME**_____**.**

Wingate Dental Care Mission Statement

Our mission is to maintain Wingate Dental Care as Union County's premier dental practice by providing a world class experience for our patients. Our team values and strives for incredible comprehensive dental care to all of our patients in a compassionate, professional and state-of-the-art environment.

We encourage you to visit our website at www.wingatedentalcare.com and our blog at www .norwooddentalblog.com

We look forward to seeing you!
Wingate Dental Care Staff

WINGATE DENTAL CARE
PATIENT ACQUAINTANCE FORM

Name_____Address_____

City_____State_____Zip_____Social Sec._____

Phone:(H)_____(W)_____(Cell)_____

E-mail address_____

Marital status_____Drivers License #_____Birthdate_____

Responsible Party_____

Employer Names & Number_____

Dental Insurance Company Name_____

Address_____

Group#_____ID#_____Phone_____

MEDICAL HISTORY

1. Yes__No__ Are you allergic to any medications or materials such as latex?
   If so what?_____
2. Yes__No__ Do you take aspirin or blood thinners, have excessive bleeding, or anemia?
3. Yes__No__ Do you have a history of artificial heart valves, heart infection, damaged valves, abnormal heart condition, murmur, or heart disease (including heart attack)?
4. Yes__No__ Has any doctor recommended that you take premedication before dental treatment?
5. Yes__No__ Do you have high blood pressure?
6. Yes__No__ Do you have an artificial joint (knee,hip, shoulder, etc.)?
7. Yes__No__ Are you or have you taken Fosamax, Actonel, Boniva, or other drugs for osteoporosis or other bone diseases?
8. Yes__No__ Are you taking birth control?
9. Yes__No__ Are you pregnant or nursing?
10. Circle any that apply: Arthritis, Diabetes, Cancer ,HIV, TB, Hepatitis, Drug addiction, Epilepsy, Venereal disease, Stroke, Asthma, Thyroid disease, Mental Health Issues, or any condition not listed-

List all medications._____

DENTAL HISTORY

1. What dental problems are you currently having?:_____
2. When was your last visit to a dentist?_____
3. What was it for?_____
4. Have you had x-rays in the last year_____

Medical doctor name and phone_____

Pharmacy name & phone_____

In case of emergency, notify_____phone_____

Signature Date

DENTAL TREATMENT CONSENT FORM

Dentist's Name: _____ Patient's Name: _____

Please read and sign at the bottom of form.

☑ **1. X-RAYS**

☑ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

☑ **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

☑ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

☑ **5. CROWNS, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

☑ **6. DENTURE, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

☑ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

☑ **8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand Periodontal or Gum Disease is a chronic destructive disease and there are no guarantees of outcomes of treatment. The Dentist may refer me to a Specialist.

☑ **9. FILLINGS**

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

☑ **10. DENTURES**

I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems.

Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

☑ **11. LOCAL ANESTHETIC**

Rarely posted complications occur such as prolonged numbness or adverse reactions.

I have read all of the above treatment informed consent information.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

WINGATE DENTAL CARE
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ACKNOWLEDGEMENT 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

_____
Date

For Office Use Only

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

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

_____

_____

_____

WINGATE DENTAL CARE

Dr. Jonathan C. Allen, Jr.
Dr. Mark D. Lassiter, Sr.

To all of our patients,

We would like to take this opportunity to thank you for your continued support and patronage. Our office continually strives to provide quality dental care at reasonable prices.
As a reflection of our desire to be more patient friendly, we will be implementing a new financial policy as of June 30, 2014. The new plan is as follows:

- ❑ Payment is due when services are rendered-payable with cash, check, debit or major credit cards, or Care Credit. Extensive treatment plans paid in full prior to treatment will be extended a 5% courtesy discount.
- ❑ Our office is not a PPO or Preferred Provider Organization for any dental insurance company. Insurance will be filed with the patient co-pay and deductible due in full when treatment is done. Please present your dental insurance card to the front desk upon arrival.
- ❑ Extended payment plans are available and will be through an outside financing source, Care Credit. Application and acceptance for financing can be validated the same day.
- ❑ Any outstanding accounts without payments past 90 days will be treated as delinquent and subsequently turned over to a collections agency. Balances over 30 days may be subject to a 2% collection fee.

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. Once again, thank you for allowing us to serve you.

Sincerely,

Jonathan C. Allen, DDS

Mark D. Lassiter, DDS

Jonathan C. Allen, DDS

Mark D. Lassiter, DDS

I have read and understand the financial policy

_____ _____

Patient Date

WINGATE DENTAL CARE
Authorization for Release of Information – Compound Release

Name of Patient Date of Birth

Mark D. Lassiter, II, PLLC, is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released. Check each** that can be given to person/entity on the left in the same section.
☐ VoiceMail	☐ Appointment Reminders Other _____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Treatment Plans
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Treatment Plans
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ X-Rays ☐ Breach notification
☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication,	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised August 2013