Dr. Christine R. Wenrick DMD, PLLC
TMJ Pain - Headaches - Sleep Disorders

1745 Memorial Drive
Clarksville, TN 37043
931.551.3351
info@TMJandSleepTreatment.com

# WELCOME TO OUR OFFICE!

Thank you for selecting our office to partner in your journey to discover the root cause of your symptoms. It is our goal to provide you with the best health care you deserve, in the most comfortable atmosphere possible.

During your initial visit, you can expect a thorough examination by Dr. Wenrick. Our goal is to first provide you with an answer as to why you are experiencing the symptoms that you have. You will then receive a diagnosis and treatment plan.

To comprehensively assess your health, we will start to gather and organize necessary information even before you enter our office for the first time. Therefore, please fill out the enclosed forms and bring them with you to your appointment. You may also fill them out on your computer and email them back to us. In addition, review the list sent to your email, and prepare each item if applicable.

It is important to show up to your appointment on time, with the completed paperwork and other needed materials in hand, as this will ensure you get as much time with Dr. Wenrick as possible. **We do not allow children to accompany patients to any appointments at our office unless the child is the patient.**

**Appointment Agreement**

1.) _____ I agree to reserve my appointments with a deposit. The deposit amount will be reviewed for each appointment scheduled. **ALL** deposits are forfeited if I Cancel, Do Not Show, or Reschedule my appointments.

Minors Name: _____

Parent/Guardian Signature: _____ Date: _____

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# PATIENT REGISTRATION

**Who may we thank for referring you to our office? _____**

**Minors Information:**

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: _____

**Primary Medical Insurance Information:**

Name of Insured: _____

Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Insurance Company: _____ Group Number:_____ Subscriber ID:_____ Employer:_____

Do you have any insurance in addition to that listed above YES NO Initial _____

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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 us.

## 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 must 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.

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**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:

Dr. Christine R. Wenrick DMD, PLLC
1745 Memorial Drive, Clarksville, TN 37043
Info@TmjandSleepTreatment.com
931-551-3351

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 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.

**Minors Name: _____**

**Parent/Guardian Name: _____**

**Patient/Guardian 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 Dr. Christine R. Wenrick named above to release health information identifying me [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 as needed to make a thorough diagnosis.

3. _____I authorize photos and radiographs to be emailed to referring providers.

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

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.

**Minors Printed Name: _____**

**Parent/Guardian Name: _____**

**Parent/Guardian 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**

At our office we do all that we can to help you understand your insurance coverage. As of now, treatment for TMJ Disorders and Sleep Breathing related problems fall under Medical Insurance, not dental. In addition, most coverage for TMJ care is limited to surgery. Most non-surgical care for TMJ Disorders is not yet organized for negotiation by insurance companies. For this reason, we do not file with Medical Insurance Companies. However, we will provide you with a claim form and medical necessity to send to your insurance company for reimbursement.

1. _____I agree to pay the office of Dr. Christine R. Wenrick, DMD, PLLC at the time services are rendered. I understand that I must pay the office directly and must file a claim with my Medical Insurance for any reimbursement.

2. _____I understand that this office has no relationship with my insurance company. I agree to be responsible for all communication with my insurance company, involving practices such as determining eligibility and benefits, covered services, denied claims, etc.

3. _____I understand that my insurance may not cover services for TMJ or Sleep Breathing Disorders at this office.

**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 imposes interest at twenty-four (24%) per annum.

5. _____I understand that if I choose to have my 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.

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**Cancellation Agreement**

6. _____I understand time is precious for both me and my care team. Dr. Wenrick and her staff take pride in seeing one patient at a time. I agree to respect their busy schedule and will be prompt with my 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 and agree that all failed, cancelled, or rescheduled appointments will result in the loss of my appointment deposit.

**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.

11._____ I understand that any and all conversations and interactions with Dr. Wenrick and staff may be audio recorded at any time for quality assurance, training, and dictation purposes.

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: _____**

**Printed Name: _____**

**Patient Signature: _____**

**Date: _____**

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# PERMISSIONS FROM LEGAL GUARDIAN

I, _____ am the legal guardian of:

Child's Name _____

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

Name of Caregiver _____

Name of Caregiver _____

In addition, inn 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, 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.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

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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 be used if there is an outstanding balance on your account not paid for by you or your insurance company. This includes charges for short-notice cancellations, no-shows and broken appointments without 48 hours advance notice of cancellation. Upon your request, we will 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.*

**If you prefer to not authorize a credit card for account payments:**

I, _____, understand that the office of Dr. Christine R. Wenrick does not mail out statements and will contact me by phone to collect outstanding account balances.

Signature: _____

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# HEALTH AND TMJ HISTORY

Use the space provided to list the required information needed for your new patient exam. If you run out of room, continue writing your information on the back of the page.

**TMJ Symptom History:** In chronological order, provide a summary of your TMJ symptoms (including information such as how long you have been dealing with the symptoms, onset, progression, etc.).

**Trauma History:** List all previous trauma you have had, and their treatments with their results in chronological order. Regardless of whether you feel the trauma has impacted your TMJ symptoms, they all have importance when it comes to piecing the puzzle together.

**Current Medications:** List all medications that you are currently taking, include dosage, how long you have been taking them, and why. If you have a printed medications list with this information on it, make sure to bring a copy with you and write below "see med list."

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**Allergies:** List all medications that cause an allergic reaction. In addition, list all sensitivities and allergies.

_____

_____

_____

_____

It is required that you answer ALL the following questions.

1. Have you ever had an X-ray, MRI or CT Scan of your Temporomandibular Joints or bite? If yes, why was the imaging done? Where and when?

_____

_____

_____

* If yes, do you have copies of the imaging? – **Bring copies of the imaging** with you. If you do not have copies, contact the facility that did the imaging and request a disk. You will most likely need to pick the disk up.

2. Have you ever had a sleep study done? When? Where? What was the diagnosis?

_____

_____

_____

* If yes, **bring a copy of your sleep study/studies** with you or have them sent to the office. If you were diagnosed with Obstructive Sleep Apnea and wear a CPAP mask, **bring your CPAP mask** with you to your appointment.

3. Do you currently wear an oral appliance (including splints, bite blocks, bite guards, retainers, or anything else worn on the teeth)? List what kind and how long you have been wearing each appliance.

_____

_____

_____

* If yes, **bring all oral appliances with you**. It is extremely important to bring all oral appliances to your new patient exam, so do not forget!