10930 Pendleton Pike, Suite 104
Indianapolis IN 46236
Office: 317-559-5955

Cancellation Policy

Winding Ridge Dentistry has a 24-hour cancellation/rescheduling policy. If at any time the appointment is missed, cancelled or changes with less than 24 hours notice, there will be a $30.00 charge. Appointment will be canceled if not confirmed within 24 hours.

We realize that there are many things that come up in people's day-to-day lives. While truly sympathetic, the practice cannot absorb the financial responsibility of last-minute cancellations. The practice doesn't double book appointment times, but rather reserve specific times for each patient affording individual care.

In fairness to all patients, this policy is in effect regardless of the reason for the cancellation.

By signing below, you acknowledge that you have read and understand the cancellation policy Winding Ridge Dentistry has described above.

Thank you for your understanding and cooperation.

_____ _____

Signature Date

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Patient Information

_____ _____ _____
First name Middle Last

_____ _____ _____
Address City/State Zip Code

_____ _____ _____
Cell Phone# DOB SSN #

_____
Email Address

Insurance Information:

_____
Carrier name

_____
Member ID

_____ _____
Phone number Group /Name number

Relationship to Subscriber

- Self
- Spouse
- Child
- Other _____

Medical Health

Emergency Contact: _____ Cell Phone: _____

Are you allergic to any of the followings:

☐ Penicillin ☐ Sulfa ☐ Latex ☐ Aspirin ☐ Ibuprophen
☐ Pain meds ☐ others _____

- Are you pregnant or trying to get pregnant Yes No
- Are you under physician's care Yes No
  - If so what is the name of your physician? _____
  - His/hers number _____
- Are you taking any medications, if so please list them?
  - _____
  - _____
  - _____
- Have you had any surgery in the past Yes No
  - If so what type of surgery? _____
- Do you tobacco Yes No
  - If so how many packs a day _____
  - How long have you been smoking_____
- When was your last dental visit _____

Do have any of the following diseases. Please mark the ones that applies

○ High blood pressure	○ Low blood sugar	○ Rheumatism
○ Low blood pressure	○ High blood sugar	○ Gout
○ Heart attack	○ Fever	○ Cancer
○ Diabetes Type I/ II	○ Hepatitis	○ Chemotherapy
○ Epilepsy	○ Crohn's	○ Tonsillitis
○ Kidney diseases	○ Stroke	○ Tonsillectomy
○ Blood transfusion	○ Headache	○ Hemophilia
○ Asthma	○ GERD	○ Covid
○ Osteoporosis	○ Skin Diseases	○ Sinus issues
○ Arthritis	○ COPD	○ Emphysema
○ HIV	○ Tuberculosis	○ Migraines
○ Anemia	○ Sciatica	○ Flu and colds

Others that are not listed: _____

- Have you been hospitalized Yes No
  - If yes, for what reason_____
- Your pharmacy name _____
  - Address_____
  - Phone Number _____

Winding Ridge Dentistry

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Indpls, In 46236,

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Notice of Privacy Practices Acknowledgement

Name of Patient _____

By signing this form, you will consent to our use and disclosure of you Protected Health Information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payments for services provided to you through third- party payers.
- To conduct normal healthcare operations such as quality assessments…etc.

I have received/been offered a copy of Winding Ridge Dentistry notice of Privacy practice office and review which contains a more complete description of the uses and disclosures of my protected health information (PHI) and my rights under HIPAA.

I understand that you reserve the right to change the terms of the notice from time to time and that I may contact you at any time to obtain a most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature _____ Date: _____

Guardian or parent signature if minor _____ Date: _____