Welcome
Angela S. Wingate, DDS, PA

Welcome To Our Practice!

Our entire dental team is committed to providing you with the highest standard of personalized dental care in a positive, warm, efficient, and professional manner. We are confident that our exceptional skills, friendly atmosphere, and comfortable accommodations will make you delighted that you have joined our growing family of patients. If there are ever any suggestions on how we may improve your visit, feel free to let us know.

In our efforts to maintain high standards of care, we stress the importance of honoring your scheduled appointment. We understand that unforeseen emergencies may arise. It is our office policy that you give us at least 24 hours advanced notice if you ever need to cancel or reschedule an appointment. For patients that fail to come to their scheduled appointment, or have cancelled within 24 hours of their appointment, a $40.00 fee will be charged to your account.

Our office hours are Mon- Thu. from 7:30 am - 4:00 pm. Because emergencies arise, we ask that a parent or guardian remain in the waiting area during the entire dental visit of their child under the age of 18.
We respectfully request that you please refrain from cell phone use in clinical rooms.

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	**Marital status** (circle one) Single / Mar / Div / Sep / Wid	**Birth Date:** / /	**Age:**	**Sex:** ☐ M ☐ F	**SSN:**

Street Address: _____ City: _____ State: _____ ZIP: _____

P.O. Box: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Work Phone: _____ Employer: _____

How did you find our office? (Please check one box.)
☐ Dr. ☐ Insurance Plan ☐ Family/Friend ☐ Internet ☐ Close to home/work ☐ Yellow Pages ☐ Other

INSURANCE INFORMATION

Is this patient covered by: Insurance? ☐ **yes** ☐ **no** Discount Plan? ☐ **yes** ☐ **no**

** If you have any questions about your dental coverage, please review with your employer's benefit administrator.

Patient's relationship to subscriber: _____

Subscribers Name _____

Subscriber's Home Address: _____

Subscriber's SSN: _____ Subscriber's Birth Date: _____ / _____ / _____

Subscriber's Employer: _____

Name of Insurance Company: _____ Group # _____

Insurance Company Address: _____ Member/ Policy # _____

INSURANCE ASSIGNMENT:

I authorize and request my insurance company to pay directly to the dentist or dental group my insurance benefits that would otherwise be payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Patient (or Parent's) Signature: _____ **Date:** _____