



PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ NICKNAME: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 SEX: M F MARITAL STATUS: M S D W SS.#: _____ DOB: _____
 CELL PHONE: _____ HOME PHONE(landline): _____ E-MAIL: _____
 EMPLOYER & OCCUPATION: _____ WORK PHONE: _____
 DENTAL INSURANCE NAME: _____ CUSTOMER SERVICE PHONE #: _____
 SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____ RELATIONSHIP TO PATIENT: _____
 SUBSCRIBER ID/SS#: _____ GROUP/PLAN# _____
 RESPONSIBLE PARTY INFORMATION (who is responsible for the bill) IF SAME AS PATIENT, PLEASE CHECK HERE: _____
 FIRST NAME: _____ LAST NAME: _____ DOB: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 CELL PHONE: _____ WORK PHONE: _____ HOME: _____
 SOC. SEC. #: _____ RELATIONSHIP TO PATIENT: _____
 IN CASE OF EMERGENCY PLEASE NOTIFY: _____ RELATIONSHIP TO PATIENT: _____
 EMERGENCY CONTACT CELL PHONE: _____ WORK PHONE: _____
 HOW DID YOU HEAR ABOUT OUR OFFICE?: _____

MEDICAL INFORMATION

In order to provide comprehensive dental treatment, we need to be more familiar with your general health history, some conditions could affect your dental health, thus altering your treatment needs. Please take a moment to respond to the following items.

NAME OF FAMILY PHYSICIAN: _____ PHONE NUMBER: _____

Current Tobacco Product use? Yes ___ No ___ Past Tobacco use? Yes ___ No ___ If yes, what products do/did you use? _____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? (please place a checkmark for each condition that applies)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tumor history | <input type="checkbox"/> Chronic Sinus problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Chest pains (Angina) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Herpes Simplex Virus |
| <input type="checkbox"/> AIDS / HIV+ | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Human Papilloma Virus |
| <input type="checkbox"/> Padgett's Disease | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Gum Disease, did you receive treatment? _____ |
| <input type="checkbox"/> Systemic Lupus | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Bisphosphonate Drug Use (Osteoporosis Drug) |

*** NONE OF THE ABOVE CONDITIONS APPLY TO ME _____

OTHER SYSTEMIC CONDITIONS/ Please explain any checked conditions: _____

MEDICATION ALLERGIES (please check all that apply) No Known Drug Allergies ___ Amoxicillin ___ Aspirin ___ Clindamycin ___

Codeine ___ Erythromycin ___ Ibuprofen ___ Penicillin ___ Other: _____

ARE YOU TAKING ANY DRUGS, MEDICATION, OR PILLS? Y N Please list with reason for each medication

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? Y N EXPLAIN: _____

WOMEN: ARE YOU PREGNANT? Y N DUE DATE: _____ **BP** _____ **P** _____

DENTAL HISTORY

NAME OF PREVIOUS DENTIST: _____ Phone _____

WHEN WAS YOUR LAST DENTAL VISIT AND WHAT WAS DONE ? _____

HOW OFTEN DO YOU BRUSH ? _____ AND FLOSS ? _____ DO YOU USE AN ELECTRIC TOOTHBRUSH? Y ___ N ___

ON A SCALE OF 1-10 (1=not important, 10=extremely) HOW IMPORTANT ARE YOUR TEETH TO YOU? _____

In your own words, please explain to us what your chief complaint of your dental health is. Also, is there anything regarding your past dental care or experiences you would like for us to know before beginning any treatment?

Please check YES or NO for each question

Yes ___ No ___ DO YOU HAVE A SPECIFIC PROBLEM WHICH NEEDS IMMEDIATE ATTENTION? _____

Yes ___ No ___ ARE YOU APPREHENSIVE ABOUT DENTAL CARE? PLEASE EXPLAIN: _____

Yes ___ No ___ HAVE THERE EVER BEEN ANY COMPLICATIONS WITH PREVIOUS DENTAL TREATMENT?

Yes ___ No ___ DOES YOUR JAW EVER CLICK OR POP WHILE OPENING OR CLOSING?

Yes ___ No ___ DOES YOUR JAW EVER CAUSE YOU ANY PAIN WHILE OPENING, CLOSING, OR ANY OTHER TIME?

Yes ___ No ___ DO YOU SUFFER FROM FREQUENT HEADACHES? RINGING IN YOUR EARS?

Yes ___ No ___ HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?

Yes ___ No ___ HAVE YOU EVER HAD PROLONGED OR UNUSUAL BLEEDING?

Yes ___ No ___ HAVE YOU EVER HAD COMPLICATIONS OR ILLNESS FOLLOWING DENTAL TREATMENT?

Yes ___ No ___ HAVE YOU EVER HAD AN INJURY OR TRAUMA TO YOUR FACE OR JAW?

Yes ___ No ___ ARE YOU DISSATISFIED WITH YOUR TEETH AND THEIR APPEARANCE? PLEASE EXPLAIN:

Yes ___ No ___ ARE YOU CONCERNED ABOUT THE FINANCES REQUIRED TO RETURN YOUR MOUTH TO EXCELLENT DENTAL HEALTH?

TREATMENT AUTHORIZATION AND ACKNOWLEDGMENT

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE, FOR THE DIAGNOSIS OF DENTAL DISEASE, DEFORMITY, OR TREATMENT OF A DENTAL EMERGENCY. THESE PROCEDURES MAY INCLUDE RADIOGRAPHY, MODELS, AND INTRAORAL EXAMINATION. IN THE CASE OF DENTAL EMERGENCY, I CONSENT TO TREATMENT AS DEEMED NECESSARY BY THE DOCTOR, UNDERSTANDING THAT THE PROCEDURES WILL BE EXPLAINED IN ADVANCE. I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT ANY PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE TREATMENT RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, will be used as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AUTHORIZING PAYMENT DIRECTLY TO NORTHLAND DENTAL STUDIO, P.A. OTHERWISE PAYABLE TO MYSELF. This payment will not exceed my indebtedness to the above mentioned assignee.

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

THE UNDERSIGNED SHALL ASSUME ALL RESPONSIBILITY FOR ALL COLLECTION AGENCY COSTS AND OTHER RELATED COSTS INCLUDING ATTORNEY FEES INCURRED WHILE COLLECTING THE AMOUNT DUE.

THE UNDERSIGNED AGREES TO GIVE REASONABLE NOTICE OF TWO (2) BUSINESS DAYS (Monday-Thursday) TO CHANGE AND/OR CANCEL SCHEDULED APPOINTMENTS. ANY APPOINTMENTS CHANGED AND/OR CANCELLED WITH LESS NOTICE WILL BE ASSESSED A MINIMUM FEE OF \$50.00 PER SCHEDULED HOUR.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ **DATE** _____

DOCTOR SIGNATURE _____ **DATE** _____



Financial Policy

Payment is expected on the day that service is rendered. If you are a patient with Dental Insurance Benefits we will, as a courtesy to you, file your dental claim and allow up to 45 days for payment. If you have a secondary policy, we will submit claims on your behalf, but payment will go directly to you. Any balance following receipt of the primary insurance has to be paid in full prior to us submitting to your secondary plan.

Please be advised that dental insurance only pays a part of your treatment. Deductibles, co-pays, and usual, customary, and reasonable limitations reduce benefits. You are responsible for all portions not covered by your benefit plan. Based on the information that you provided us, we will try to estimate what your benefit plan will pay. **However, you are ultimately responsible for all incurred charges.** Payment arrangements must be made prior to scheduling your treatment. **If there are any changes to your benefit plan, it is your responsibility to inform the office a minimum of 48 hours prior to your appointment so that we can verify your new benefits.**

We accept Cash, Personal Checks (not third party checks), VISA, MasterCard, Discover and we will assist you with payment plan options through CareCredit. There will be a \$25.00 fee assessed for all returned checks for insufficient funds.

Minors, children under the age of 18, are to be accompanied by a parent or legal guardian and that person will be financially responsible for the child.

Appointment Policy: We kindly request a minimum of **two (2) business day's (Monday-Thursday)** notice to change appointments. Patient's that fail to provide this notice, or, who do not show up for an appointment will be charged a fee of **\$50.00** for each hour scheduled. Appointments scheduled for **90 minutes or longer will require a \$150.00 non-refundable deposit to reserve the appointment.** This deposit will be applied to your co-payment. Broken appointments or failure to provide proper notice of appointment changes will result in the forfeiture of your deposit.

* I have read and understand the above policies.

Patient Name(print): _____ **Signature:** _____ **Date:** _____
(Patient or Guardian)

HIPAA Policy, Texas SB-300 and Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Communications: With this consent I hereby give Northland Dental Studio permission to contact me via US Postal service, e-mail and telephone (home/cell/work and permission to leave a message on voice mail or in person) in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Healthcare Operations) such as appointment reminders, insurance items, statements, marketing material and any calls pertaining to my clinical care.

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices, I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare options.

Signature: _____ **Date:** _____
Patient or Guardian

Northland Dental Studio may discuss my finances, clinical or emergency care with the following person(s):

Name _____ Relationship _____