PATIENT INFORMATION

Patient's name: _____ Preferred name :_____ Birth date:_____

If minor, parents names :_____ Phone:_____ Work: _____

Mailing address _____ City _____State _____ Zip _____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance ❑ Unmarried ❑ Married

Member ID:_____ Social Security Number:_____ Dental Insurance Co.:_____

Member's name:_____ Member's employer: _____

Covered by spouse's insurance? ❑ Yes ❑ No

Spouse's name :_____ Spouse's employer :_____

Spouse's dental insurance company :_____ Group number: _____

Spouse's birthday :_____ Social Security Number/Member ID:_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur/Pacemaker, mitral valve prolapse, heart defect
- ❑ Stroke/Heartattack
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Thiroid Disease
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism/Subsance abuse
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Mental Health problems/diseases
- ❑ Arthritis
- ❑ Eating or Sleeping Disorders?
- ❑ Herpes or cold sores/Sexually Transmitted Disesase's
- ❑ Glaucoma
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

❑ Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives?

DENTAL HEALTH HISTORY

- ❑ How often do you brush? ____ How often do you floss?____
- ❑ Are you apprehensive about dental treatment?
- ❑ Does food catch between your teeth?
- ❑ Do you gag easily?
- ❑ Do your gums bleed easily?
- ❑ Do you have difficulty in chewing your food?
- ❑ Are your teeth sensitive?
- ❑ Are you dissatisfied with the appearance of your teeth?
- ❑ Do you clench or grind your jaws frequently?
- ❑ Do your jaws ever feel tired?
- ❑ Does your jaw get stuck so that you can't open freely?
- ❑ Does it hurt when you chew or open wide to take a bite?
- ❑ Do you wake up with any jaw symptoms or headaches morning?
- ❑ Are you aware of an uncomfortable bite?
- ❑ Have you had a blow to the jaw (trauma)?

Name of your physician:_____ Please add anything else you would like us to know about?:_____

Do you have any disease, condition, or problem not listed above?_____

Signature of patient (or parent) _____ Date _____

A NORTHWEST

DENTAL

Name: _____ Date: _____

Email Address: _____

Is it ok to write a detailed message at this email address (please circle): YES NO

Best Number to Reach You? (H) (C) (W) _____

Is it ok to leave a detailed message at this phone number (please circle): YES NO

Preferred Method of Contact (please circle): Phone Email

Office Policies and Consent

Cancellations must be made 48 hours in advance or a cancellation charge will apply.

I fully understand I am solely responsible for any balance not paid by my insurance company. I am financially responsible for any services rendered including legal fees, collection agency fees, interest charges and any other expenses incurred in collecting my account. I will update the office if there are any changes in my insurance, contact info, health history, etc. or if there is treatment at another dental office.

Assignment of benefits/Records: I give permission to the dental office to bill my dental insurance for the treatment provided. I authorize the dentist to release any information required to process my claims. I also authorize the dentist to release any records and x-rays as requested.

Informed consent: I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that all treatment carries some risk and possible side effects. In addition, I know that written copies of the risks are available to me at any time at my request. I understand that it is important that I provide my dentist with accurate information before, during, and after treatment. I understand that it is equally important to follow the dentist's advice and recommendations regarding medication, pre and post treatment instructions, referral to other dentists or specialists and return for timely appointments. I understand that failure to follow the advice of my dentist may negatively affect the outcome of my treatment.

Signature: _____ Date: _____

Financial Agreement

I have read and agree to the office Financial Policy.

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

This is to inform you about the legal requirements mandated by HIPAA (Health Insurance Portability and Accountability Act) that allows Health Care Providers to provide services to patients as long as the practice (A Northwest Dental) takes reasonable and appropriate measures to protect patient privacy.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used

- I have been given the opportunity to review the Health Insurance Portability Act (HIPAA)
- I have been given the opportunity to review A Northwest Dental "Notice of Privacy Practices"
  - Upon my request I will be provided with a copy of this material

  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.

ADDITIONAL DISCLOSURE AUTHORITY In additional to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.		
ANY MEMBER OF MY IMMEDIATE FAMILY:	YES	NO
SPOUSE ONLY:	YES	NO
OTHER (PLEASE SPECIFY):	YES	NO

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

A NORTHWEST

DENTAL

Financial Policy

Regarding Payment

- We accept the following forms of payment: Cash, Check, Visa, Discover, MasterCard, American Express and CareCredit.
- Any amount not paid by your insurance company will be your responsibility. Prompt payment will be expected.
- Unpaid accounts with balances over 90 days overdue will be sent to collection.
- If there is a special arrangement made between you and a staff member regarding payment, please ask for it in writing.

Regarding dental insurance

As a courtesy to our patients, we will file your dental claims to your dental insurance so you don't have to.

Please Note:

- **Most insurance plans have deductibles, copays, maximums, frequency limitations, downgrading, networks, etc. that can lead to out of pocket expenses.**
- **Your insurance policy is a contract between your employer/you and your insurance company.** We do not have control over what or how much is covered or over exclusions or denials, etc.
- **We recommend that you become familiar with your own dental insurance plan.** There are countless plans and each one is unique with different coverage's, exclusions, limitations and clauses. Not all information is made easily or publicly available to us as a third party to your plan.
- **Pre-Authorizations are available.** Any estimates provided by us are only our best guess with the limited information we have been provided. For a more accurate estimate, a preauthorization/pre-determination can be requested from your insurance. If interested, we can help submit one for you.
- **We are available to help.** If you have any questions regarding insurance, please ask. We are here to help.

Thank you for choosing us as your dental care provider. If you have any questions regarding this or anything else, please let us know.