Northland Dental Studio
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PATIENT INFORMATION

FIRST NAME: ____________________________________ LAST NAME: ____NICKNAME: ______________________

ADDRESS: ____ CITY: __________________________ STATE: __________ ZIP:_______________

SEX: M F MARITAL STATUS: M S D W SOC. SEC. #:____________________________________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 circle "Y" or "N", or bold "Y " or "N" for each condition)***

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

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, or, BOLD 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 TREATMENTWILL 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________

Northland Dental Studio, P.A.

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___________________________