NORTHERN SMILES FAMILY DENTAL

Patient Information

Patient Name: ______________________ ______________________________ ____________________
Last Name First Name MI Preferred Name

Social Security # _____________________ Date of Birth: __________________ Gender: _________________

Phone # (Home) ______________________ Cell: _____________________ Work: ____________________

Email Address: ____

Mailing Address: ____

____
City State Zip Code

Responsible Party Information (If same as patient, leave blank)

The following is for: ❑ The patient's spouse ❑ The person responsible for payment

Name:____

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑Other ___________

Social Security #: _______________________ Birth Date: ___________________________

Phone (Home): ___________________________ Work: ___________________________

Email:____

Address: ____
Street

____
City State Zip Code

Employment Information

The following is for: ❑ the patient ❑the person responsible for payment

Employer Name: ____________________________________ Occupation: __________________________

Address: ____

____
City State Zip Code

Insurance Information

Primary

Name of Insured: ________________________ ______________________ Is insured a patient? ❑ Yes ❑ No
Last Name Firt Name MI

Insured's Birth Date: ____________________ ID #: ____________________ Group #: _________________

Insured's Address: ____
Street City State Zip

Insured's Employer: ____

Address: ____
Street City State Zip

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other ________________________

*If you have secondary insurance, please notify one of our office staff. Thank You!

Heath History

Yes	No		Yes	No		Yes	No	
❏	❏	AIDS/HIV	❏	❏	Fainting	❏	❏	Mitral Valve Prolapse
❏	❏	Anemia	❏	❏	Glaucoma	❏	❏	Pacemaker
❏	❏	Angina	❏	❏	Hay Fever	❏	❏	Current Pregnancy
❏	❏	Arthritis	❏	❏	Head Injuries			Due Date: ________________
❏	❏	Artificial Joints	❏	❏	Heart Attack	❏	❏	Radiation Treatment
❏	❏	Asthma	❏	❏	Heart Murmur	❏	❏	Respiratory Problems
❏	❏	Blood Disease	❏	❏	Hepatitis	❏	❏	Rheumatic Fever
❏	❏	Cancer	❏	❏	Heart Attack	❏	❏	Sinus Problems
❏	❏	Chemotherapy	❏	❏	Heart Murmur	❏	❏	Stomach Problems
❏	❏	Cold Sores/fever blister	❏	❏	Hepatitis A B C D	❏	❏	Stroke (date) ____________
			❏	❏	High Blood Pressure	❏	❏	Tuberculosis
❏	❏	Diabetes	❏	❏	Jaundice	❏	❏	Ulcers/Canker Sores
❏	❏	Epilepsy	❏	❏	Kidney Disease	❏	❏	Penicillin Allergy
❏	❏	Excessive Bleeding	❏	❏	Liver Disease	❏	❏	Other:______________

- Are you under the care of a physician now? ❏ Yes ❏ No

  If yes, please explain: ____

- Have you been hospitalized during the past two years? ❏ Yes ❏ No

  If yes, please explain: ____

- Have you ever had a serious head or neck injury? ❏ Yes ❏ No

  If yes, please explain: ____

- Do you have artificial joints or heart condition that required an antibiotic? ❏ Yes ❏ No
- Are you allergic to (i.e., itching, swelling, rash) or made sick by penicillin, aspirin, codeine, or any other drugs or medications? ❏ Yes ❏ No If yes, please explain: ________________________________
- Are you taking any medication (including over the counter medications? ❏ Yes ❏ No

  If yes, please list: ____

  ____

- Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate? ❏ Yes ❏ No
- Are you taking any blood thinners/anticoagulant drugs? ❏ Yes ❏ No

  Date of last INR and INR #: ____

Dental Health

- Are you currently having any pain or discomfort? ________________________________
- Last Dental Examination? ______________________
- Date of Last Dental Cleaning? ______________________
- Have you ever been told you have Periodontal Disease (Gum Disease)? ❏ Yes ❏No

  It yes, was it treated with Scaling and Root Planing (Deep Cleaning)? ❏ Yes ❏No

- Are you happy with your smile ? ❏ Yes ❏No

  If no, what would you change?______________________________

- Would you like a whiter smile? ❏ Yes ❏ No
- Are you interested in straightening your teeth? ❏ Yes ❏ No
- Do your gums bleed when brushing or flossing? ❏ Yes ❏ No
- Do you clench or grind your teeth during wake or asleep? ❏ Yes ❏ No
- Do you have frequent headaches? ❏ Yes ❏ No
- Do your jaws feel tired or sore when awake? ❏ Yes ❏ No
- Do your jaw joints grind, pop, click or lock? ❏ Yes ❏ No
- Are you apprehensive about receiving dental treatment? ❏Yes ❏ No

Release/Consent:

A. I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease or treatment of dental emergencies. These procedures may include radiographs, models and intraoral examination. In case of a dental emergency, I consent to treatment as deemed as necessary by the doctor, understanding that the procedures will be explained in advance.

B. I give consent to the use of local anesthetics and relaxants for completing the necessary dental treatment.

C. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits

D. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist if being referred.

E. I nearby authorize payment of ignorance benefits directly to the dentist or dental group, otherwise payable to me

F. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payments in full for all accounts.

G. I attest to the accuracy for the information of these pages. I understand that it is my responsibility to inform the Doctor and the office staff of any changes in my medical status at the very next appointment, before any further treatment is rendered to me.

H. I have either been given the opportunity to review or instructed on how/where to receive a copy of the HIPPA paperwork.

______________________________________ ____________

Patient or Guardian Signature Date

______________________________________ ____________

Doctor Signature: Upon Completion Date

Financial Policy:

Payment – We require payment in full at the time of service. For your convenience we accept cash, personal checks, Visa, MasterCard, Discover and American Express. We also offer payments via Care Credit. Prior to service, we will review with you the treatment that will be completed along with your patient responsibility. Please understand that payment of your bill is considered part of your treatment, and you will be required to make any financial arrangements prior to any work being performed.

Submission – As a courtesy we will prepare and submit your insurance forms for reimbursement if we have been given all necessary information for submission. We cannot bill your insurance company unless you bring in all of your insurance information. Please keep the following in mind:

- The balance is your responsibility whether your insurance company pays or not.
- Your insurance policy is a contract between you and your insurance company. We are not a party to contact.
- Please be aware that some and perhaps all of the dental services performed by Northern Smiles Family Dental may be "non-covered" services and not considered reasonable and necessary under your dental contract.

Patient Portion: Your patient portion will be estimated and due on the day of service. This estimate is based on information received by our staff from your insurance company and is only an approximate amount. Patient portions which are underestimated will be billed immediately after payment is received from your insurance company. Checks which do not clear with your bank will be assessed a $25.00 service charge for reprocessing. Once a check does not clear your bank account, it will no longer be considered as an acceptable form of payment.

I have read the above, and do understand and agree to the financial policy

____ ____________________

Patient or Guardian Signature Date