Northwest
DENTAL CARE
of West Fork

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart # _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ __ _____
Last First MI Preferred Name

Title: _____ Gender: _____ Family Status: Married __ Single __ Child __ Other __
(Mrs./Ms./Mr./Miss)

Birth Date: ___/____/___ SSN: _____-____-_____ E-mail: _____

Phone: _____ _____ _____ ____
HOME MOBILE WORK Ext

Address: _____ _____ ___ _____
CITY STATE ZIP CODE

Preferred Choice of Contact:
Please select your preferred method(s) of contact about appointments:

Phone Call ____ Text Messaging ____ E-mail _____

Preferred Appointment Times:
Mon _____ Tue _____ Wed _____ Thurs _____ Morning _____ Afternoon _____

Whom may we thank for referring you to our practice?
Dental Office _____ Yellow Pages ___ Internet ___ Newspaper ___ School ___
Connect Care ___ Work ___ Facebook___ Other:_____

Dental History
Do you have any pain from any area of your mouth? _____ When was your last visit? _____

When was your last dental cleaning? _____ Former Dentist: _____

Difficulties with dental treatment/adverse Rx: _____

Please answer the following on a scale from 1-10 (1 being the least and 10 being the greatest):

I rate my current overall dental health: 1 2 3 4 5 6 7 8 9 10
I would like my overall dental health to be: 1 2 3 4 5 6 7 8 9 10
Improving my dental health is a priority: 1 2 3 4 5 6 7 8 9 10
Are your teeth as white as you would like them to be? _____
Are you interested in implants? _____

439 N. Centennial Ave | PO Box 760 | West Fork, AR 72774
(479) 839-2273 | Fax (479) 839-2274 | www.NorthwestDentalCare.com

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Medical History:

Primary Physician's Name: _____ Phone # : _____

Preferred Pharmacy Name: _____ Phone #: _____

Are you under medical treatment now? _____ If yes, please describe: _____

_____

Are you currently taking any medications including non-prescription medicine? ____ If yes, please list medications and dosage_____

_____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment: _____

_____

Do you smoke or use nicotine products? _____ If yes, how often? _____

Are you now or have you ever taken a prescription for osteoporosis? _____

Are you now or have you ever taken a blood thinner other than aspirin? _____

Women Only: Are you pregnant or think you may be pregnant? _____ If yes, what week? _____

Do you take birth control? _____

Do you have or have you had any of the following? Please indicate with a "√".

___ Abnormal/Excessive Bleeding
___ Acid Reflux
___ Alcohol Abuse
___ Anemia
___ Arthritis
___ Artificial Bones
___ Asthma
___ Autism
___ Blood Disease
___ Blood Thinner
___ Blood Transfusion
___ Cancer (type: _____)
___ Congenital Heart Defect
___ COPD/Respiratory Problems
___ Diabetes
___ Dizziness
___ Dry Mouth
___ Epilepsy or Seizures
___ Fainting
___ Fever Blisters
___ Frequent Headaches
___ Gag Reflex
___ Glaucoma
___ HIV/AIDS Infection
___ Heart Disease
___ Heart Murmur
___ Heart Surgery
___ Hepatitis A B C D E
___ High Blood Pressure
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Lupus
___ Memory Loss/Alzheimer's
___ Pace Maker
___ Psychiatric Problems
___ Sickle Cell Disease
___ Sinus Problems
___ Sleep Apnea
___ Stroke
___ Thyroid Problems
___ Tuberculosis
___ Ulcers/Stomach Problems
___ Venereal Disease

ALLERGIES

___ Aspirin
___ Codeine
___ Dental Anesthetics
___ Erythromycin
___ Food (type: _____)
___ Gluten
___ Latex
___ Metals
___ Nuts
___ Penicillin
___ Tetracycline
___ Other: _____

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Responsible Party Information

The following is for: ___ the patient's spouse ___ the person responsible for the payment ___ self

Name: _____ _____ __ _____
Last First MI Preferred Name

Gender: _____ Family Status: Married __ Single __ Child __ Other__

Birth Date: ___/___/___ SSN: _____-____-_____ E-mail: _____

Phone: _____ _____ _____ ____
HOME MOBILE WORK Ext

Address: _____ _____ ___ _____
CITY STATE ZIP CODE

Employment Information for Responsible Party

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

Employer Name: _____ Phone #: _____
(Employer Name/Disable/Retired/Unemployed)

Address: _____ _____ ___ _____

Primary Dental Insurance

Insured Name: _____ _____ __ Birth Date: ___/___/___
Last First MI

SSN: _____-____-_____ ID#: _____ Group #: _____

Insurance Name: _____

Phone Number: _____ Plan Name: _____

Address: _____ _____ ___ _____
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Patient's Relationship to Insured: ____ Self ____ Spouse ____ Child ____ Other

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Authorization to Discuss Patient Information

I authorize Northwest Dental Care to discuss my personal health information with:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Note: We will not talk to anyone that is not on this list regarding your care except third party payers and/or specialist involved in your care.

Consent for Services

Notice of Privacy Practices
I may refuse to sign this acknowledgement.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Financial Policy
Payment or deductibles and/or co-pays are due at the time services are rendered. We do not provide financing of dental services, however, financing is available through Care Credit or iCare. We also accept cash, check, money order, or credit card (MasterCard, Visa, or Discover Card). Returned checks are subject to a fee.

In order to expedite any insurance payments, please provide us with your current insurance card so we can keep a copy on file. We will file any insurance claims for you as a courtesy and will assist you in any way to insure that you receive your just benefits for services provided. However, your insurance policy is a contract between you, your employer, and your insurance company. By signing below, you acknowledge that all fees for services provided are ultimately your responsibility in the event your insurance does not pay or cover certain procedures.

In the event there is an account balance that is not paid within 90 days of service, it will become subject to a third party collection agency and a $50.00 collection fee will be added to the account.

Cancellation Policy
We kindly request 24 hours notice when canceling/rescheduling appointments. We are very respectful of your time; we ask that you do the same. After 3 missed/canceled appointments without proper notice, you may be dismissed as a patient or subject to a $100.00 missed appointment fee. If you are more than 15 minutes late for an appointment, you may be asked to reschedule.

Other
We may take Pre-Op and Post-Op photos as needed for your treatment plan and insurance purposes. None of our photos will be used for advertisement or placed on social media without your consent and an additional release form.

Thank you for choosing us as your dental provider. Our main goal is to provide you the treatment needed to restore and maintain your oral health. We sincerely appreciate your trust in us. The opportunity to care for our patients is something we take seriously. It is important that we have your correct address information and phone numbers on file. Please advise us anytime there is any change to your contact information.

_____ *I have read the above policy and accept full financial responsibility for my dental treatments. Your signature below is stating that you agree with our Consent for Services policy.*

These forms expire in 2 years or when patient reaches the age of 18.

Signature of the patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to patient: _____

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