

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? _____

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? _____

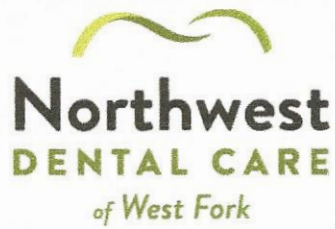
Are you now or have you ever taken a blood thinner other than aspirin? _____

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 "√".

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal/Excessive Bleeding | <input type="checkbox"/> Gag Reflex | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ulcers/Stomach Problems |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> HIV/AIDS Infection | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Artificial Bones | <input type="checkbox"/> Heart Surgery | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A B C D E | ALLERGIES |
| <input type="checkbox"/> Autism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Food (type: _____) |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Lupus | <input type="checkbox"/> Gluten |
| <input type="checkbox"/> COPD/Respiratory Problems | <input type="checkbox"/> Memory Loss/Alzheimer's | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Nuts |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Thyroid Problems | |



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

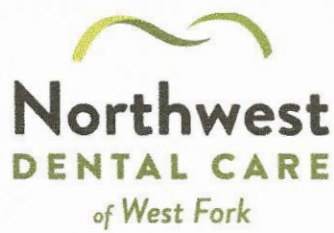
SSN: ___-___-___ ID#: _____ Group #: _____

Insurance Name: _____

Phone Number: _____ Plan Name: _____

Address: _____
CITY STATE ZIP CODE

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



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: _____