

---

7421 State Route 366  
Huntsville, Ohio 43324  
937-843-3932



---

202 East Fifth Street  
Marysville, Ohio 43040  
937-642-3434

*The mission of Northwest Family Dental is to provide quality dental care to each patient while educating them to total wellness and dental health. We provide a service that exceeds your expectations.*

## FINANCIAL POLICY

It is our commitment to deliver high quality and comprehensive healthcare in a warm, caring environment. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To better assist you with your healthcare investment, below is an outline of our financial policy.

For patients with a dental benefit, please remember that the contract is between you and your insurance carrier, not between the doctor and the insurance carrier. Treatment recommendations are always based on your unique dental needs, not by insurance limitations. Our business team would be happy to provide a complimentary benefits check. For questions regarding specific coverage issues, reference your insurance handbook or contact your insurance company

Our policy is as follows:

- All professional services are the responsibility of the patient. We will file all insurance claims via our electronic software as a courtesy to all of our patients. Your estimated balance for services will be collected the same day service is rendered. You are responsible for services not covered by your dental benefit.
- Select insurance policies such as Delta Dental, Superior Dental, or any other such policy remit payment to the subscriber, not Northwest Family Dental. It is the patient's responsibility to remit the check to Northwest Family Dental.
- Payment options are:
  - Cash - includes money orders and personal checks
  - Visa, MasterCard, Discover and American Express
  - Cherry Finance and Care\*Credit - a no interest payment plan (subject to credit approval)
- There will be a \$30 fee for all returned checks.
- We reserve the right to apply a billing fee for delinquent accounts.

### Authorization and Release of Information for Billing:

I authorize my insurance benefits to be paid directly to Northwest Family Dental. I authorize the release of any information by Northwest Family Dental to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account.

By signing below, you agree to the financial policy of Northwest Family Dental, and have fully read, understand and agree to the terms of this contract and have been offered a copy of this agreement.

---

Signature of Patient

---

Date

---

Print Name

## MEDICAL INFORMATION (CONTINUED)

### YES/NO

- Are you in good health?  
  Are you currently under the care of a physician?

**Physician Information:** Please list all medical specialist that you see at least once a year. (Please print)

NAME	ADDRESS/CITY	PHONE NUMBER	NAME OF SPECIALTY

- Are you taking or have recently taken any prescription or over the counter medicines?  
 If YES, please list. \_\_\_\_\_
- Do you regularly take herbal medications or dietary supplements?  
 Specifically, do you take (circle all that apply): Echinacea/Feverfew/Garlic/Ginger/Ginko/Ginseng/Kava/St. John's Wort/Valerian/Vitamin E
- Have you ever taken weight loss medication? If YES, have you taken the following? (circle all that apply): Fen-phen/Pondimen/Redux/Other
- Have you undergone current or past osteoporosis therapy? (Examples are: Fosamax/Actonel/Boniva pill form)
- Have you undergone current or past therapy to reduce high blood calcium? (Examples are intravenous Aredia, Zometa)
- Are you or have you ever been addicted to a chemical substance? (Example: alcohol, prescription drugs, heroin, meth, cocaine, other)
- Do you currently drink alcohol or recreational drugs?
- Do you smoke or use smokeless tobacco?  
 If YES, what type of tobacco do you use? \_\_\_\_\_ How interested are you in quitting? Very Interested/Interested/Not Interested?
- Has there been any changes in your general health within the past year?
- Have you had a serious illness, operation or been hospitalized in the past five years?  
 If YES, please list: \_\_\_\_\_

Please mark a (√) to indicate if you have or have not ever had any of the following diseases/problems listed in the columns below.

### YES/NO

### YES/NO

### YES/NO

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease         | <input type="checkbox"/> <input type="checkbox"/> Excessive Urination                | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care           |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease        | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding                 | <input type="checkbox"/> <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> <input type="checkbox"/> Allergies/Hay Fever/Hives  | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures                  | <input type="checkbox"/> <input type="checkbox"/> Recent weight Loss         |
| <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis                | <input type="checkbox"/> <input type="checkbox"/> Eating Disorder                    | <input type="checkbox"/> <input type="checkbox"/> Recurrent Infections       |
| <input type="checkbox"/> <input type="checkbox"/> Anemia/ Blood Disease      | <input type="checkbox"/> <input type="checkbox"/> Fainting Spells/ Dizziness         | <input type="checkbox"/> <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> <input type="checkbox"/> Angina                     | <input type="checkbox"/> <input type="checkbox"/> Frequent Diarrhea                  | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis       |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                     | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches                 | <input type="checkbox"/> <input type="checkbox"/> Rash                       |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion          | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> <input type="checkbox"/> Breathing Problems         | <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure               | <input type="checkbox"/> <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur/Irregular Heart Beat  | <input type="checkbox"/> <input type="checkbox"/> Sleeping Disorder          |
| <input type="checkbox"/> <input type="checkbox"/> Bruise Easily              | <input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker                    | <input type="checkbox"/> <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/ Leukemia           | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble/Disease              | <input type="checkbox"/> <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy/ Radiation    | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure            | <input type="checkbox"/> <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pains                | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS                           | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> <input type="checkbox"/> Cold Sores/ Fever Blisters | <input type="checkbox"/> <input type="checkbox"/> Hemophilia/Bleeding Problems       | <input type="checkbox"/> <input type="checkbox"/> SLE (Lupus)                |
| <input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A, B or C (circle type)  | <input type="checkbox"/> <input type="checkbox"/> Spleen Removed             |
| <input type="checkbox"/> <input type="checkbox"/> Cardiovascular Disease     | <input type="checkbox"/> <input type="checkbox"/> Herpes                             | <input type="checkbox"/> <input type="checkbox"/> Steroid Therapy            |
| <input type="checkbox"/> <input type="checkbox"/> Chronic/ Frequent Cough    | <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia                       | <input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Convulsions                | <input type="checkbox"/> <input type="checkbox"/> Impairment of Speech/Sight/Hearing | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine         | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems                    | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> <input type="checkbox"/> Liver Disease/Yellow Jaundice      | <input type="checkbox"/> <input type="checkbox"/> Tumors/Growths             |
| <input type="checkbox"/> <input type="checkbox"/> Damage Heart Valve         | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse              | <input type="checkbox"/> <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> <input type="checkbox"/> Easily Winded              | <input type="checkbox"/> <input type="checkbox"/> Pain in jaws or joints             | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease           |

**Please complete the Health History Form and then sign below:**

Northwest Family Dental request this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of the Northwest Family Dental office will be provided this information unless authorized by you or required by law. Failure to provide the requested information will limit the ability to access your needs and may result in Northwest Family Dental being unable to accept you as a patient. By signing below, you agree that this information given is accurate and that you will notify Northwest Family Dental at subsequent appointments if there are changes in your health.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature & Date: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_



*Welcome! So that we may provide you with the best possible care.  
Please complete both sides of this dental/ medical history form.  
All information is completely confidential.*

## DENTAL INFORMATION

What is the reason you are seeking dental care? \_\_\_\_\_

Please list your PREVIOUS dental provider below:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone Number)

Date of your: last: dental cleaning & exam \_\_\_\_\_ Full mouth series of x-rays \_\_\_\_\_

Please answer the following questions by marking an (✓) in the columns provided below

### YES/NO

- Are you happy with your smile?
- Would you like your teeth to be whiter?
- Are your teeth sensitive to hot/ cold/ sweets/ pressure?
- Do your gums bleed when you brush or floss?
- Does food/ floss get caught between your teeth?
- Is your mouth dry?
- Do you get sores or ulcers in your mouth?
- Do you participate in recreational activities?
- Do you wear a mouth guard?

### YES/NO

- Have you had a serious injury to your mouth or head?
  - Do you have earaches, headaches, neck pain?
  - Do you drink bottled water or filtered water?
  - Is your water supply fluoridated?
  - Has fear or an upsetting dental experience kept you from seeking dental care?
- Indicate YES to treatment that you experienced by marking on (✓) in the boxes below.
- TMJ/ Bite Splint Therapy       Denture/ Partial       Root Canal
  - Periodontal (gum) treatment       Orthodontics (braces)       Crown
  - Fillings       Implant

## MEDICAL INFORMATION

**Allergies:** Please indicate NO/ YES to any previous reactions to items below. To all YES responses, SPECIFY TYPE OF REACTION.

### YES/NO

- Local anesthetics \_\_\_\_\_
- Penicillin \_\_\_\_\_
- Other antibiotics \_\_\_\_\_
- Sulfa Drugs \_\_\_\_\_

### YES/NO

- Codeine Drugs \_\_\_\_\_
- Latex (rubber) \_\_\_\_\_
- Aspirin \_\_\_\_\_
- Metals \_\_\_\_\_

### YES/NO

- Acrylic \_\_\_\_\_
- Barbiturates, sedatives or sleeping pills \_\_\_\_\_
- Iodine \_\_\_\_\_
- Other \_\_\_\_\_

Has any physician or previous dentist recommended that you take antibiotics prior to your dental treatment? YES/NO

If YES, please list: Physician/ Dentist name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please indicate YES/NO to any diseases/problems listed in the columns below.

### YES/NO

- An artificial (prosthetic) heart valve?
- A damaged valve in a transplanted heart?
- A congenital heart disease (CHD)?
- An unrepaired, cyanotic CHD?
- A repaired (completely) in the past 6 months?
- A repaired CHD with residual defects?

### YES/NO

- Have you had infected endocarditis (heart infection)?
- Have you had a total knee/hip joint replacement?  
If YES, when was it placed? Date: \_\_\_\_\_
- If YES, have you had any complications? \_\_\_\_\_

(Please complete other side)

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



IF THIS APPOINTMENT IS FOR YOU START HERE

Date			
Last Name		First	M.I.
Prefers to be called by			
Address			
City		State	Zip
Home Phone No.		Fax	
Cell		Email	
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security No.			
Date			
Last Name		First	M.I.
Address			
City		State	Zip
Home Phone No.			
Birthdate	Age	Male	Female
School		Grade	
Social Security No.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DENTAL INSURANCE	
PRIMARY CARRIER	
Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's I.D. No.	
Insured's Social Security No.	
SECONDARY CARRIER	
Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's I.D. No.	
Insured's Social Security No.	

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
Name		
Relationship to Patient	Social Security No.	
Address		
City	State	Zip
Phone No.		
YOU		
Name		
Occupation		
Employer's Name		
Address	City	
Phone No.	Fax No.	
YOUR SPOUSE		
Name		
Occupation		
Employer's Name		
Address	City	
Phone No.	Fax No.	

GETTING TO KNOW YOU		
<b>Is another member of your family or relative a patient at our office:</b>		
Name:	Relationship:	
<b>You were referred to us by</b>		
<b>Your former address</b>		
City	State	Zip
<b>Person to contact for emergency</b>		
Phone number		
Address		
City	State	Zip
<b>Closest relative not living with you</b>		
Phone number		
Address		
City	State	Zip

Please turn over and sign

---

7421 State Route 366  
Huntsville, Ohio 43324  
937-843-3932



---

202 East Fifth Street  
Marysville, Ohio 43040  
937-642-3434

### CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Parent/ Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_

7421 State Route 366  
Huntsville, Ohio 43324  
937-843-3932



202 East Fifth Street  
Marysville, Ohio 43040  
937-642-3434

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT  
PATIENT CONSENT FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- 2. Obtain payment from third-party payers.
- 3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I have received, read and understand your *Notice of Privacy Practice*. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information be used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**Patient Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\*\*\*\*\*

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

---

7421 State Route 366  
Huntsville, Ohio 43324  
937-843-3932



---

202 East Fifth Street  
Marysville, Ohio 43040  
937-642-3434

## **CHANGE OF APPOINTMENT POLICY:**

At Northwest Family Dental, we understand that unforeseen circumstances may arise, leading to the need for appointment cancellations or rescheduling. We strive to provide exceptional dental care and accommodate our patients' needs to the best of our abilities. However, to ensure the smooth operation of our practice and to serve all our patients efficiently, we have established the following cancellation policy:

### **1. Appointment Cancellation or Rescheduling:**

- a. We kindly request that you provide at least 24 to 48 hours' notice if you need to cancel or reschedule your appointment. This allows us to offer the time slot to another patient in need of dental care.
- b. If you fail to provide at least 24 hours' notice or do not show up for your appointment, it will be considered a "late cancellation" or a "no-show."

### **2. Late Cancellation or No-Shows:**

- a. For late cancellations, we allow a one-time exception for this. If a late cancellation happens for a second time, meaning less than 24 hours' notice, the patient will then be subjected to same day scheduling versus being pre-appointed for their dental work.
- b. If a patient no shows their appointment, and they are an established patient of record, that patient will be subjected to a same day scheduling for their next visit.
- c. If a new patient fails to show up for their new patient exam and cleaning, and calls or messages to reschedule this appointment with less than 24 hours' notice, they will need to pay a rebooking fee of \$100 to get back on the schedule. This fee will then be a credit on their account that will be applied to any out-of-pocket costs for their first appointment with us, as well as any subsequent treatment that may be needed in the future.

### **3. Exceptions:**

- a. We understand that emergencies and unforeseen circumstances can occur. If you have a genuine emergency or unavoidable situation, please contact our office as soon as possible to discuss your situation.

### **4. Repeated Late Cancellations or No-Shows:**

- a. Repeated late cancellations or no-shows may result in limitations on future appointment scheduling or dismissal from the practice.

b. If you have a history of late cancellations or no-shows, we may require a non-refundable deposit or prepayment for future appointments.

5. Appointment Reminders:

a. We provide appointment reminders via phone call, text message, or email, based on your preferred method of communication.

b. It is your responsibility to ensure that we have accurate contact information and to confirm your appointment details.

By scheduling an appointment at Northwest Family Dental, you acknowledge and agree to abide by our cancellation policy. We appreciate your understanding and cooperation in helping us provide the best possible dental care to all our patients.

Please note that this cancellation policy is subject to change at the discretion of Northwest Family Dental. Any updates or modifications will be communicated to you in advance.

If you have any questions or concerns regarding our cancellation policy, please feel free to contact our office.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name