Patient Demographics

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws.

General Information

First Name - Patient

Middle Name

Last Name - Patient

Nickname/Preferred Name

Prefix/Honorific

Degree/Suffix

Gender

○ Male ○ Female ○ Other

Patient Date of Birth

Marital Status

Preferred Language

Email Address

How did you find us?

Contact Information

Home #

(___) ___-____

Work #

(___) ___-____

Mobile #

(___) ___-____

Patient Mailing Address

Line 1

Line 2

City

Country

Patient Billing Address

Line 1

Line 2

City

Country

Guarantor/Parent Information (If applicable)

Responsible Party Name

Relationship to Patient

Responsible Party Date of Birth

Responsible Party SSN *

Employer's Name

Work Phone Number

Other Information

Emergency contact

Emergency #

(___) ___-____

Family Doctor

Family Doctor Phone #

(___) ___-____

Employer

Employer Phone #

(___) ___-____

Occupation

Social Security Number

Driver's License Number

Previous Provider

Previous Provider Phone #

(___) ___-____

Non-Verbal Communication

Insurance Information

Primary Insurance Carrier

Primary Insurance Group Number

Primary Insurance Subscriber Name

Primary Insurance Subscriber ID

Primary Subscriber Date of Birth

Secondary Insurance Carrier

Secondary Insurance Group Number

Secondary Insurance Subscriber Name

Secondary Insurance Subscriber ID

Secondary Subscriber Date of Birth

Consent for Text Messages

We may use your contact information to provide you with text message reminders about appointments and treatment. You can opt out of receiving these text messages at any time. We will not share your contact information or opt-in with any third parties or affiliates without first obtaining your consent. By signing this form you are acknowledging that you read this statement.

Print name

Date

I agree that the information provided in this form is correct to the best of my knowledge.

Signature *

Clear

Patient Health Information

First Name - Patient *

Middle Name

Last Name - Patient *

Patient Date of Birth

Gender *

Male Female Other

Occupation

PHONE/CONTACT INFORMATION

Mobile #

(___) ___-____

Home #

(___) ___-____

Email Address

Preferred Contact Method

Emergency contact

Emergency #

(___) ___-____

Patient Mailing Address

Line 1

Patient Billing Address

Line 1

Line 2

Line 2

City

Country

City

Country

MEDICAL/HEALTH HISTORY

Are you taking any prescription medications? *

- Yes
- No

If you answered yes to medications, please list below. If you answered no, please write none. *

In the past 5 years, have you ever been hospitalized or had any type of surgery?

Yes No

Have you ever been instructed to take ANY special precautions or medications before any dental appointments?

Yes No

Do you smoke, vape or use chewing tobacco products?

Yes No

If yes, explain below

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

- ◯ Yes
- ◯ No

Have you ever been diagnosed with sleep apnea?

- ◯ Yes
- ◯ No

Do you use controlled subtances?

- ◯ Yes
- ◯ No

If yes, explain below

Are you under the care of a physician?

- ◯ Yes
- ◯ No

If yes, please provide physician information below

Do you take or have taken Phen-Fen or Redux?

- ◯ Yes
- ◯ No

If yes, explain below

Have you taken Fosamax, Boniva, Actonel or any bisphosphonate medications?

- ◯ Yes
- ◯ No

If yes, explain below

Are you on a special diet?

- ○ Yes
- ○ No

If yes, explain below

DENTAL/ORAL HEALTH HISTORY

Please check the boxes for all YES answers

- ☐ Are you currently experiencing dental pain or discomfort?
- ☐ Are your teeth sensitive to cold, hot, sweets, or pressure?
- ☐ Do you grind your teeth?
- ☐ Do you have any clicking, popping, or discomfort in your jaw?
- ☐ Have you ever had a serious injury to your head, neck, or mouth?

PHARMACY INFORMATION

Preferred Pharmacy

Pharmacy #

(___) ___-____

ALLERGIES

Allergies

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local anesthetic
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other

Please elaborate on any reactions you have to the indicated allergies

CONDITIONS

Conditions

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood disease
- [ ] Blood Thinners
- [ ] Blood transfusion
- [ ] Breathing Problem
- [ ] Breathing problems/respiratory disease
- [ ] Bruise Easily
- [ ] Cancer/chemotherapy/radiation treatment
- [ ] Chest Pains
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Thirst
- [ ] Fainting Spells/Dizziness
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Heart Attack/Failure
- [ ] Heart murmur
- [ ] Heart Trouble/Disease
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] Hepatitis, jaundice or liver disease
- [ ] Herpes
- [ ] High blood pressure
- [ ] High Cholesterol
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney problems
- [ ] Leukemia
- [ ] Low blood pressure
- [ ] Lung Disease
- [ ] Mitral valve prolapse
- [ ] Osteoporosis/Paget's disease
- [ ] Pacemaker
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Psychiatric care
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Renal Dialysis
- [ ] Rheumatic fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus trouble
- [ ] Spina Bifida
- [ ] Stomach/Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice

- [ ] Other

Do you have any disease, condition or problem that is not listed that you think I should know about?

Signature *

Clear

Insurance Verification

First Name - Patient *

Last Name - Patient *

Primary Insurance Information

Name of Employer

Name of Insurance Company

Group Number

Subscriber Name

Subscriber Date of Birth

Payer Address (located on back of insurance card)

Carrier Phone Number

(___) ___-____

Secondary Insurance Information

Name of Employer

Name of Insurance Company

Group Number

Subscriber Name

Subscriber Date of Birth

Subscriber ID

Payer Address (located on back of insurance card)

Carrier Phone Number

(___) ___-____

Office Policy Form

Northwest Family Dental Office Policies

Our goal is to provide high quality care to our patients, and to respect their schedule as well. When you schedule and appointment, we reserve that time and prepare in anticipation of serving you. In fairness to other patients, and the office staff, we require advance notice when changing or cancelling an appointment of at least 48 hours. We understand that conflicts arise; however, failing your appointment or cancelling without adequate notice of 48 hours or more may result in forfeiture of your appointment time. If this occurrence happens more than once, it may result in a rebooking fee or same day scheduling.

Patients who continue to no-show and/or cancel without notice may be dismissed from the practice, and asked to find another dentist.

Any patient who is late may be be considered a "no show" for their appointment, and may need to be rescheduled. If running behind, we kindly ask that you call our office so that we can prepare for your late arrival, or try and find a time that better suits your schedule in order adequately serve you.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan, and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above appointment policy.

First Name

Last Name

Date / Time

Signature

Clear

Financial Policy

Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.

If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.

Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

The clinic will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

First Name

Last Name

Signature

Clear

Date

HIPAA Notice of Privacy Practices

HIPAA Notice of Privacy Practices

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of the responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may not be able to grant your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has the authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the top of the page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ ocr/ privacy /hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal law require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy, I may request it from the office.

First Name

Last Name

Date

Signature

Clear