NORTHCUTT DENTAL

Thank you for choosing **Northcutt Dental** as your health care provider.
To better serve you, we ask all patients to complete our patient information form completely before seeing the dentist or hygienist. PLEASE PRINT CLEARLY.

PATIENT INFORMATION (AGES 17 AND UNDER)

Name: _____ _____ _____ _____
Last Name First Name Middle Name Preferred Name

Address: _____ Apt#: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SSN: _____ – _____ – _____ DOB: _____ / _____ / _____ ☐ Male ☐ Female

How did you hear about us: ☐ Radio ☐ Television ☐ Insurance ☐ Internet ☐ Walk-In/Sign ☐ Mailer

☐ Dentistry from the Heart ☐ Referral/Name: _____ ☐ Other: _____

Who in your family has been here before? _____

In case of emergency, whom should be contact? (Someone not living with child)

Name: _____ Relationship to child: _____

Phone: _____ Address: _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _____ Relationship to Patient: _____

Mother/Legal Guardian's Name: _____ Work Ph: _____ Cell Ph: _____

Father/Legal Guardian's Name: _____ Work Ph: _____ Cell Ph: _____

Email address for confirming appointments: _____

Does the patient have insurance? ☐ Yes ☐ No **(If no, skip to next page)**

Primary Insurance Company: _____ Subscriber's Relationship to Patient: _____

Subscriber's Name: _____ _____ _____
Last Name First Name Middle Name

Date of Birth: _____ / _____ / _____ SSN: _____ – _____ – _____

Subscriber's Employer: _____ Employer Phone: _____

Additional Insurance? ☐ Yes ☐ No

Secondary Insurance Company: _____ Subscriber's Relationship to Patient: _____

Subscriber's Name: _____ _____ _____
Last Name First Name Middle Name

Date of Birth: _____ / _____ / _____ SSN: _____ – _____ – _____

Subscriber's Employer: _____ Employer Phone: _____

I hereby authorize payment directly to Northcutt Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Northcutt Dental to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Patient Signature (Responsible Party) Date

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Is your child currently under medical treatment? ☐ YES ☐ NO If yes, for what? _____

MEDICATIONS:

List any medications you are currently taking and why:

Medication:	**Reason for Use:**

Check any known allergies:

None	☐	Local Anesthetics	☐
Aspirin	☐	Penicillin	☐
Codeine	☐	Other:_____	☐
Latex	☐		

Check "YES" or "NO" for each of the following:	YES	NO
Anemia/Free Bleeder	☐	☐
Asthma	☐	☐
Blood disease	☐	☐
Cancer (type: _____)	☐	☐
Diabetes: Type I or Type II	☐	☐
Epilepsy or seizures	☐	☐
Head Injuries	☐	☐
Heart Problem	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Mental Disorders	☐	☐
Respiratory Disease	☐	☐
Tuberculosis	☐	☐

Does your child have any other health issues we should be aware of? ☐ YES ☐ NO

If yes, for what? _____

_____

ASSIGNMENT and RELEASE

I give permission for Northcutt Dental and their clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my child's dental needs.

I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I understand that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

_____ _____

Parent Signature (Responsible Party) Date

FOR OFFICE USE ONLY

DATA ENTERED BY: _____ INITIALS

COPY OF DL AND/OR INS CARD MADE BY: _____ INITIALS

SCANNED TO DOCUMENT CENTER BY: _____ INITIALS

FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please read carefully.

ALL INSURANCE COPAYMENTS, DEDUCTIBLES, AND ESTIMATED PATIENT PORTIONS ARE DUE ON THE DATE TREATMENT IS PERFORMED. We accept cash or Visa/MasterCard/American Express/Discover. We offer an extended payment plan with credit approval. We do not accept checks.

REGARDING INSURANCE

We are happy to accept assignment of insurance benefits from your insurance carrier. As a courtesy to you, we will file your insurance, help you maximize your benefits, and estimate both your insurance coverage and your portion due. Your estimated portion is due upfront (before treatment) on date of service. Should your insurance company refuse to comply with assignment of benefits, you may be asked to pay your bill in full and be reimbursed by your insurance company. **The balance is the patient's responsibility whether the insurance company pays or not.** If the insurance company has not paid the account in full within 45 days, the balance becomes the patient's responsibility. Should Northcutt Dental Practice have to expend any fees (collection, court cost, etc) to collect any payment portion, insurance or other, these fees will automatically become the patient's responsibility. Please be aware that some and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under some dental insurance policies.

RETURN CHECK FEE FOR MAILED PAYMENTS

Any returned check will incur a $ 50.00 NSF fee.

PAYMENT OF SERVICES

Your estimated portion is due upfront (before treatment) on date of service.

MINOR PATIENTS

The adult accompanying a minor is responsible for seeing that payment is made in full. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements have been made for payment by cash, credit card or pre-approved credit plan.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. If an appointment must be rescheduled, please give us at least 24 hours notice. For Monday appointments, we need to know of changes by noon on Friday at the latest. It is our policy to charge $50 for each missed appointment. Should the problem continue, you may be asked to prepay appointments to reserve the appointment time.

AGREEMENT TO PAY COLLECTION FEES ADDED TO ACCOUNT BALANCES

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

CONSENT TO CONTACT PATIENT BY CELL PHONE OR E-MAIL

You agree, in order for us to service your account or to collect monies you may owe, Northcutt Dental Practice and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which can result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

By signing below, you agree that you have read, understand and agree to this Financial Policy. Please let us know if you have any questions or concerns regarding our Financial Policy. We look forward to serving your dental needs.

Patient Signature (Responsible Party) _____ Date _____