

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

Name: _____
Last Name First Name Middle Name Preferred Name
Address: _____ Apt: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Work Phone: _____
Email: _____ Male Female
SSN: _____ - _____ - _____ Single Married Divorced Widowed
DOB: _____ / _____ / _____
Employer: _____ Occupation: _____
How did you hear about us? _____
Who in your family has been here before? _____
In case of emergency, whom should be contact? _____ Phone: _____

DENTAL INSURANCE

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

FOR OFFICE USE ONLY

DATA ENTERED BY: _____
INITIALS

COPY OF DL AND/OR INS CARD OBTAINED: _____
INITIALS

SCANNED TO DOCUMENT CENTER BY: _____
INITIALS

MEDICAL HISTORY

Physician's Name: _____

Date of Last Visit: _____

Check "YES" or "NO" for each of the following: YES NO

Are you currently under medical treatment? YES NO
If yes, for what? _____
Have you ever had any serious illnesses or operations? YES NO
If yes, for what? _____

MEDICATIONS:

List any medications you are currently taking and why:

<u>Medication:</u>	<u>Reason for Use:</u>

Check any known allergies:

None Local Anesthetics
Aspirin Penicillin
Codeine Other: _____
Latex

Check "YES" or "NO" for each of the following: YES NO

Do you smoke or use tobacco products? YES NO
Do you drink alcohol? YES NO
Do you use cocaine or other drugs? YES NO
Do you have a history of using illegal/street drugs? YES NO
Are you taking a blood thinner? YES NO
Do you believe you need pre-medication? YES NO
If yes, for what? _____

BONE DENSITY MEDICATIONS YES NO

Are you taking/have you taken bone density medication (bisphosphonates) also known as "bone builders" for osteoporosis, cancer treatment, post-menopause, etc? YES NO
If you are taking or have taken any bone density medications, please indicate IV or PILL:

	IV	PILL		IV	PILL
Boniva (Brandronate)	<input type="checkbox"/>	<input type="checkbox"/>	Aredia (Pamidronate)	<input type="checkbox"/>	<input type="checkbox"/>
Fosamax (Aledronate)	<input type="checkbox"/>	<input type="checkbox"/>	Didronel (Etidronate)	<input type="checkbox"/>	<input type="checkbox"/>
Actonel (Risecronate)	<input type="checkbox"/>	<input type="checkbox"/>	Zometa (Zoledronic acid)	<input type="checkbox"/>	<input type="checkbox"/>
Other Bone Density Medication: _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Check "YES" or "NO" for each of the following: YES NO

AIDS/HIV positive YES NO
Anemia/Free Bleeder YES NO
Arthritis, Rheumatism YES NO
Artificial Heart Valve (Date: _____) YES NO
Artificial Joints (Date: _____) YES NO
Asthma YES NO
Blood disease YES NO
Cancer (type: _____) YES NO
Chemotherapy/Radiation Treatment YES NO
Circulatory problems YES NO
Dependency: Alcohol or Chemical YES NO
Diabetes: Type I or Type II YES NO
Emphysema YES NO
Epilepsy or seizures YES NO
Fainting or dizziness YES NO
Glaucoma YES NO
Head Injuries YES NO
Headaches YES NO
Heart Attack (Date: _____) YES NO
Heart Disease YES NO
Heart Murmur YES NO
Hepatitis (Type: _____) YES NO
High blood pressure YES NO
Immune System Disorder YES NO
Jaundice YES NO
Kidney Disease YES NO
Liver Disease YES NO
Low Blood Pressure YES NO
Mental Disorders YES NO
Nervous problems YES NO
Pacemaker YES NO
Psychiatric Care YES NO
Respiratory Disease YES NO
Scarlet Fever/Rheumatic Fever YES NO
Sexually Transmitted Disease YES NO
Sinus trouble YES NO
Stroke (Date: _____) YES NO
Thyroid problems YES NO
Tuberculosis YES NO
Tumor or Growth YES NO
Pregnant/Nursing (**Women Only**) YES NO

ASSIGNMENT and RELEASE

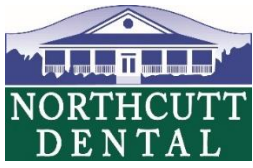
I give permission for Northcutt Dental and their clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

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 health.

Patient Signature (Responsible Party)

Date



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 COPAYMENTS, DEDUCTIBLES, AND/OR 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 will 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 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.

MISSED APPOINTMENTS: There is a \$50.00 Late Cancellation/No Show Fee for patients who do not call us at least 24 hours in advance to cancel or reschedule any appointment not requiring a deposit.

DEPOSITS: Most appointments require a deposit ranging from \$50.00-\$200.00 depending on the service. This deposit goes towards the cost of treatment, but is non-refundable if the appointment is cancelled or rescheduled without a 24-hour advanced notice.

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.

CREDIT CARD PAYMENTS: We have a 3% Cash/Debit discount built into all pricing. A fee of 3% will be assessed to each credit card transaction, which is not greater than our cost of acceptance.

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.

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.

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 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.

LATE ARRIVAL POLICY: To ensure timely service for all our patients, we kindly ask that you arrive on time for your scheduled appointment. We offer a 10-minute grace period; if you arrive later than this, we may need to reschedule your appointment.

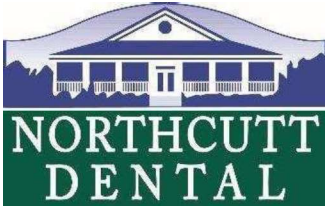
LATE CANCELLATIONS & NO-SHOWS: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice. A "no-show" is someone who misses an appointment without cancelling it in an adequate manner.

- First late cancellation or no-show: courtesy reschedule
- Second late cancellation or no-show: \$50.00 Late Cancellation/No Show Fee must be paid before scheduling any future appointments.
- Third late cancellation or no-show: Discharge from the Practice.

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

Patient Signature (Responsible Party)

Date



Authorization for Release of Information

Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent.

Many of our patients allow family members such as their spouse, parents, or others to call and request dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize **Northcutt Dental Practice** to release my dental and/or billing information to the following individual(s):

- 1. _____ Relation to Patient: _____
- 2. _____ Relation to Patient: _____
- 3. _____ Relation to Patient: _____

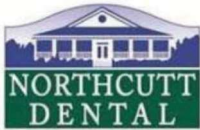
____ I elect **not** to disclose my PHI to anyone at this time.
Initial

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Signature (Responsible Party)

Date



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Northcutt Dental Practice's Notice of Privacy Practices, which has an effective date of 01/01/2018, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient (If not signed by the Patient)