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

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? | ☐ | ☐ |
| If yes, for what? _____ | | |
| Have you ever had any serious illnesses or operations? | ☐ | ☐ |
| 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 |
|---|---|---|
| Do you smoke or use tobacco products? | ☐ | ☐ |
| Do you drink alcohol? | ☐ | ☐ |
| Do you use cocaine or other drugs? | ☐ | ☐ |
| Are you taking a blood thinner? | ☐ | ☐ |
| Do you believe you need pre-medication? | ☐ | ☐ |
| 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? | ☐ | ☐ |

If you are taking or have taken any bone density medications, please indicate IV or PILL:

| | IV | PILL | | IV | PILL |
|---|---|---|---|---|---|
| Boniva (Brandronate) | ☐ | ☐ | Aredia (Pamidronate) | ☐ | ☐ |
| Fosamax (Aledronate) | ☐ | ☐ | Didronel (Etidronate) | ☐ | ☐ |
| Actonel (Risedronate) | ☐ | ☐ | Zometa (Zoledronic acid) | ☐ | ☐ |
| Other Bone Density Medication: _____ | | | | ☐ | ☐ |

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

# 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 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)