Northwood Dental

DENTAL HISTORY

1. Date of last dental visit? ___/___/____ Date of last dental x-rays? ___/___/____
2. Name of previous dentist: _____
3. Reason for today's visit? _____
4. Do you have any concerns about previous dental care or this visit? _____

   _____
5. Do your gums bleed? *(circle)* Yes No
6. Are your teeth loose? *(circle)* Yes No
7. Have you ever been told you have gum disease? *(circle)* Yes No
8. Have you ever been told you have bad breath? *(circle)* Yes No
9. Are your teeth sensitive to? *(circle all that apply)* Sweets Cold Heat Pressure
10. Have you ever had pain in your jaw joints (clicking/popping)? *(circle* Yes No
11. Are you happy with your smile? *(circle)* Yes No

    If no, please explain:_____
12. What would you change about the present condition of your mouth? _____

***

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature:_____ Date: _____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

DENTAL REGISTRATION

PATIENT INFORMATION

Date: _____

Patient Name (last) _____

(first) _____ (middle initial) _____

Name you prefer to be called: _____

Address: _____

City: _____

State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____

Birthdate: _____

SSN: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Occupation: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Spouse/Parent Name: _____

How did you hear about us? _____

What made you want to come in? _____

ACCOUNT INFORMATION

Who is responsible for this account? _____

Relationship to Patient: _____

Do you have Dental Insurance? _____

Insurance Company: _____

Phone # _____

Group # _____

Subscriber's Name: _____

Birthday: _____ Member ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to (Name of Insurance Company) Dr. _____ all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am finanically responsible for all charges wheter or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

HEALTH HISTORY

Physician's Name: _____ Date of last physical: _____

Have you ever had any of the following:

Heart Problems	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Blood Pressure Problems	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Radiation Treatment/Cancer	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Other	☐ Yes	☐ No
Hemophilia/bleeding	☐ Yes	☐ No	Fainting/dizzyness	☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No
Respiratory Disease/Asthma	☐ Yes	☐ No	Snoring	☐ Yes	☐ No	HIV/Aids/Other	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Sinus problems	☐ Yes	☐ No			
Headaches (morning especially)	☐ Yes	☐ No	Hepatitis, Jaundice, or Liver Disease	☐ Yes	☐ No			
Excessive daytime sleepiness	☐ Yes	☐ No	Gastroesophageal Reflux Disease (GERD)	☐ Yes	☐ No			
Artificial heart valves or joints?	☐ Yes	☐ No	If yes, what was the date of surgery?					
Under the care of a physician?	☐ Yes	☐ No	If yes, for what conditions?					

(Woman) Do you suspect that you are pregnant? ☐ Yes ☐ No

Have you ever taken osteoporosis medication? ☐ Yes ☐ No How long? _____

Is there anything else we should know about your medical history? _____

MEDICATIONS

List any medications you are currently taking and why:

_____

_____

_____

ALLERGIES

☐ Aspirin ☐ Iodine ☐ Penicillin

☐ Codeine ☐ Latex ☐ Tylenol

☐ Ibuprofen ☐ Local Anesthetic ☐ Steroids

☐ Other Antibiotics: _____ ☐ Other:

_____

The above information is accurage and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient file and maintained for six years.

_____
Print Name (Patient)

_____ _____
Signature (Patient) Date

_____ _____
Parent, Guardian or Patients legal Representative Date

_____ _____
Witness Date

I also hereby authorize disclosure of information, via verbal or written communication, regarding appointments, billing, condition, treatment, and prognosis to the following individual(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINTED FOR SIX YEARS.

Northwood Dental
3023 Eastland Blvd., Suite 112, Clearwater, FL 33761

Financial Arrangements Information For Our Patients

Patients WITHOUT Dental Insurance:

Payment is due on the day, and at the time, services are rendered unless different arrangements have been made to pay the balance due, prior to the date of service.

My signature below indicates that I have read the above and understand my financial responsibilities:

_____
Print Name (Patient)

_____ _____
Signature (Patient) Date

_____ _____
Parent, Guardian or Patients legal Representative Date

Patients WITH Dental Insurance:

As there are many different insurance companies and different levels of benefit coverage that can be chosen by employers, which can change almost yearly, this information is being provided to you in order to improve understanding between you, our patient, and us regarding dental insurance.

1. As a courtesy, we will be glad to file your insurance forms for the services provided on the date the services are provided.

2. We will **estimate** what your insurance carrier will pay to the best of our ability. This is based upon the information you provide to us. If you have any information to help us estimate the benefits of your plan, such as a contract or a breakdown of benefits, please provide that to us.

Please turn over

3. Due to the large number of insurance companies, and employers choosing different benefit coverage within these companies, an exact estimate of coverage is not possible. Therefore, please understand that, while we do everything we can to get you the coverage you deserve, **after 30 days, you will be responsible for any balance that remains unpaid by the insurance company**

4. Your insurance policy is a contract between you and your insurance provider. If there is a dispute, we will try and help you to resolve your issue. Please be aware that, as the policyholder, your insurance company will be more likely to cooperate with you than with our office.

5. Our purpose as a dental practice is to help ensure that you have healthy teeth and gums that you can use for a lifetime. Once you establish treatment with your dentist, please be aware that your insurance plan may not cover all of the treatment you require, or may change the treatment according to what is covered by that particular plan, with no real reason to do so. Since the dental insurance company has not seen your mouth, they could not possibly know exactly what you need. Thus, completing only the treatment covered by your plan may be detrimental to your dental health.

6. Based on the estimation carried out, your portion of the total fee is due on the day, and at the time, that services are rendered, unless other arrangements have been made **prior** to the day of service.

My signature below indicates that I have read the above and understand my financial responsibilities:

_____
Print Name (Patient)

_____ _____
Signature (Patient) Date

_____ _____
Parent, Guardian or Patient's Legal Representative Date