Northside Dental

PATIENT INFORMATION *(*REQUIRED)*

*Date: ☐ NEW PATIENT ☐ UPDATE

*Patient:

FIRST MI LAST PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD ☐ STUDENT ☐ UN-MARRIED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME (MOM) PARENT/GUARDIAN NAME (FATHER)

*Patient Date of Birth: Patient SSN:

*Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

*HOME:

*CELL:

OTHER:

FAX:

*E-Mail:

*How did you hear about us?

*Referred by:

EMERGENCY INFORMATION

*In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP *Phone:

PREVIOUS DENTIST INFORMATION

*Dentist: *Telephone:

*Clinic/Facility:

*Address:

CITY ST ZIP CODE

*Reason for changing:

*Permission to request x-rays/ chart: ☐Y ☐N

DENTAL INSURANCE INFORMATION **Insurance** We are ***NOT*** an in-network provider for your plan. (*It is your responsibility to know your plan details)* We will obtain your benefits to keep on file and we will do everything it takes to maximize your reimbursement by filing claims for you. Please understand, you are responsible for all charges for services provided to you

Subscriber's Name:_____DOB:_____ SSN:_____

Carrier Name:_____ID#:_____Group#:_____

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DENTAL HISTORY *(PLEASE ANSWER ALL QUESTIONS)*

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

Would you like to have an oral cancer screening? ☐Y☐N

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns or goals regarding your dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS ☐ANTIHISTAMINES/ALLERGY ☐DAILY ASPIRIN ☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS ☐CANCER/CHEMO MEDS ☐CORTISONE/STEROIDS ☐HEART MEDICATION/DIGITALIS
☐INSULIN ☐NITROGLYCERIN ☐ORAL CONTRACEPTIVES ☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS ☐RECREATIONAL DRUGS ☐THYROID MEDICATIONS ☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

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ARE YOU **ALLERGIC** OR HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- ☐ ASPIRIN
- ☐ ANESTHETIC – LOCAL
- ☐ BARBITURATES
- ☐ CODEINE
- ☐ IODINE
- ☐ IBUPROFEN
- ☐ LATEX
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ ANTIBIOTICS-LIST:
- ☐ NONE
- ☐ OTHER PLEASE LIST:

☐Y ☐N Any hospitalization in the past 5 years?

☐Y ☐N Any serious illnesses/surgeries?

☐Y ☐N Use tobacco in any form or marijuana? If yes, what type:

☐Y ☐N *Is pre-medication required before dental visits due to heart condition or artificial joint?*

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER'S
- ☐ BLEEDING DISORDER
- ☐ BULIMIA
- ☐ CANCER/MALIGNANCY
- ☐ CEREBRAL PALSY
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS/FAINTING
- ☐ ENDOCARDITIS
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT HEADACHES
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS (CIRCLE) A B C
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ MITRAL VALVE PROLAPSE
- ☐ MONONUCLEOSIS
- ☐ PACEMAKER
- ☐ OTHER – PLEASE LIST:
- ☐ PSYCHIATRIC TREATMENT
- ☐ RADIATION/CHEMO
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID CONDITION HYPO/ HYPER
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

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PLEASE CHOOSE YOUR PREFERRED METHODS OF CONTACT

I would prefer for the following auto communications to be used by Northside Dental (please check all that apply):

☐ ***Home Phone*** ☐ ***Text Messages*** ☐ ***E-Mail***

I would prefer for Northside Dental to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

☐ ***Home Phone*** ☐ ***Cell Phone*** ☐ ***Work Phone*** ☐ ***None- please just ask for a call back*** ☐ ***Other (Please explain)***

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children:

1) _____ **2)** _____ **3)** _____

FORM Us

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:_____ **Date:**_____

Northside Dental

FINANCIAL GUIDELINES: ***We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.***

Payments

- **Patient payment is due at the time services are rendered.**

- Payment Information, we gladly accept:
  - Major credit cards accepted are Visa, MasterCard, Discover. ***We do NOT accept American Express.***
  - Various financing options with CareCredit® and LendingClub®

VERY IMPORTANT PLEASE READ CAREFULLY: Short Cancel/ Missed Appointments

- **The policy is as follows; *48 hour notice for any changes or cancellations.* This is to ensure that our Doctor, Assistants' and Hygienists' time is utilized wisely. *If you will be more than 15 minutes late or if you come to your appointment and decide you need to leave, there will be a $25 fee paid at that time*.**

- **There is a *$50 an hour cancelation fee (depending on the length of time of your appointment),* if canceled less than 48 hours in advance.**

- ***It is your responsibility to call or email Northside Dental back to confirm your reservation and understand that after Northside Dental has attempted to reach you 3 times, Northside Dental will cancel your appointment and your appointment time will be forfeited*.**

- **A deposit may be required to hold some appointments.**

Should you be here for a special and receive x-rays at a discount or for free, and choose to go elsewhere, there will be a charge for the x-rays

By signing below I acknowledge I have read and understand the guidelines above

Signature:_____ **Date:**_____

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PATIENT CONSENT- PATIENT AUTHORIZATION - PAYMENT AUTHORIZATION- SIGNATURE FOR FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

I understand that during the course of treatment, it is possible to find other existing issues that may have not been seen or known before. The course of action can always change, but I will be made aware prior to changing treatment.

I hereby authorize Dr. Cera to obtain / release any information concerning my health or dental care, advice, treatment, supplies provided/ used, x-rays, chart notes, and other; information that will aide in the taking care of myself. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____Date:_____

GENERAL RISKS OF DENTAL CARE: **Include (But not limited to) are complications resulting from the use of dental instruments and medicines such as: antibiotics, analgesics (pain medications), and local anesthetic injections. These complications may include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling, permanent: reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasms: temporomandibular (jaw) joint difficulty: loosening of teeth: referred pain to ear, neck and head: nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.**

In the chance procedures are to be performed, it is very important that you provide your dentist with accurate information before, during, and after treatment. ***It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome and will void the warranty.***

If you are emailing the patient chart and x-rays, please send to
Info@NorthsideDentalSantaFe.com

If mailing, please send to:
Northside Dental
806 Calle Mejia
Santa Fe, NM 87501