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PATIENT INFORMATION *(*REQUIRED)*

*Patient: _____

FIRST MI LAST PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD ☐ UN-MARRIED ☐ MARRIED

*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: _____

*E-Mail: _____ FAX: _____

*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: _____

* Facility _____

*Address: _____

CITY ST ZIP CODE

*Reason for changing: _____ *Permission to request x-rays/ chart: ☐ Y ☐ N

DENTAL INSURANCE INFORMATION: 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)*

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 ***Drug or Alcohol abuse?*** _____

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

☐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 ***Are you happy with your smile? What would you change?*** _____

☐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?

.....

☐Y ☐N **Any hospitalization in the past 5 years? Please explain:** .....

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

Any additional concerns/comments? _____

_____

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

☐ NONE

☐ ASPIRIN ☐ CODEINE ☐ LATEX ☐ SLEEPING PILLS
☐ ANESTHETIC ☐ IODINE ☐ METAL SENSITIVITY ☐ SULFA DRUGS
☐ BARBITURATES ☐ IBUPRFN ☐ NITROUS OXIDE ☐ ANTIBIOTICS-LIST:
☐ OTHER PLEASE LIST:

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

☐ NONE

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

☐ OTHER – PLEASE LIST:

MEDICATIONS: PLEASE LIST ALL or have us make a copy for your record

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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TO BETTER SUIT YOUR WANTS/NEEDS, WE WANT TO PERSONALIZE YOUR EXPERIENCE HERE WITH US

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 AUTOMATED Voice Phone Calls***
- ☐ ***AUTOMATED Text Messages***
- ☐ ***AUTOMATED E-Mails***

I would prefer for Northside Dental to leave a message with any person or on my voicemail on 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)** _____

HIPPA CONSENT

-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 confidential 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:***_____

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PATIENT CONSENT- PATIENT AUTHORIZATION FOR X-RAYS- SIGNATURE FOR FILE

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.

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.

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

PRINTED NAME:_____

Signature: _____**DOB:**_____**Date:**_____

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