Northside Dental

PATIENT INFORMATION

NAME:_____PREFERRED NAME:_____
Date of Birth:_____ (not required unless you have insurance) *SSN:*_____

Street Address:_____
City, State, Zip:_____ EMAIL:_____

Cell Number:_____Home Number:_____ Other:_____

HOW DID YOU HEAR ABOUT US or WHO CAN WE THANK FOR REFERRING YOU?

_____

**If Child, Please Provide Mother and Fathers Names:*_____ _____
Mom *Father*

EMERGENCY CONTACT INFORMATION

*Name:*_____*Relationship:*_____*Phone:*_____

INSURANCE INFORMATION/ Out of Network Benefits

Subsc. Name:_____DOB:_____SSN:_____

Insur. Name:_____ ID#:_____Group Name:_____

Carrier Phone #:_____

PREVIOUS DENTIST INFORMATION

*Dentist Name:*_____*Office Name:*_____

*City:*_____*State:*_____*Phone:*_____

Permission to Request X-rays? Yes/ No

PLEASE READ AND SIGN

AUTHORIZATION: I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits.
ELECTRONIC COMMUNICATIONS: I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 5058203551.

- **Signature:_____ Date_____**

DENTAL HISTORY - PLEASE ANSWER ALL QUESTIONS

☐ Yes ☐ No **Are you happy with your smile? No, Explain:**

☐ Yes ☐ No Are you currently having dental discomfort?
☐ Yes ☐ No Any injuries to the head, mouth or teeth?
☐ Yes ☐ No Any missing teeth other than wisdom teeth?
☐ Yes ☐ No Are you sensitive to hot/ cold/ sweets?
☐ Yes ☐ No Are your gums swollen/ tender/ bleed
☐ Yes ☐ No Does it hurt to bite or chew?
☐ Yes ☐ No Do you have bad breath?
☐ Yes ☐ No Do you clench or grind?
☐ Yes ☐ No Do you have dry mouth?
☐ Yes ☐ No Do you have blisters on the mouth or lips?
☐ Yes ☐ No Do you have sore spots or growths in the mouth?

☐ Yes ☐ No Have you ever had an allergic reaction to Novocain, local or general anesthetic?
☐ Yes ☐ No Have you ever had to have Periodontal Treatment?
☐ Yes ☐ No Have you had heart surgery?
☐ Yes ☐ No Have you had a transplant operation that depressed your immune system?
☐ Yes ☐ No Do you have a disease/ problem you think we should know about?
☐ Yes ☐ No Have you ever had trouble with any dental procedures?
☐ Yes ☐ No Is there/ or has there been drug or alcohol abuse?
☐ Yes ☐ No Do you use tobacco (regular and/or electronic) or marijuana?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING ITEMS?

☐ Anesthetic
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ Ibuprofen
☐ Latex
☐ Metal
Sens
☐ Nitrous
☐ Sulfa
☐ Chemo Therapy Medication
☐ Heart Disease Medication
☐ Insulin Medication
☐ Antibiotics:
☐ **Other:**

___**NONE**

PREFERENCES

☐ **Do not prefer Epinephrine**
☐ **Latex Free**
☐ **Fluoride Free**
☐ **Flavor Free**
☐ **Scent Free**
☐ **Prefer Cavitron**
☐ **Prefer Hand Scaling** ___**NONE**

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING HEALTH CONDITIONS?

☐ ADHD
☐ Aids
☐ Allergies, Hay Fever, Sinusitis
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Autism/ Asperger's
☐ Bleeding Abnormally
☐ Blood Disease/ Clotting problems
☐ Bulimia
☐ Cancer
☐ Cerebral Palsy
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Diabetes
☐ Depression
☐ Dizziness/ Fainting
☐ Emphysema
☐ Epilepsy/ Seizures
☐ Endocarditis
☐ Frequent Ear/headaches
☐ Glaucoma
☐ Hearing Problems
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis Type: _____
☐ High Blood Pressure
☐ Hyper Thyroid
☐ Hypo Thyroid
☐ Immune Deficiency
☐ Kidney Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Osteopenia
☐ Osteoporosis
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Sickle Cell Anemia
☐ Sinus Trouble
☐ Slow Healing Wounds
☐ Stroke
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Weight loss, un explained
☐ **Other** ___ **NONE**

ARE YOU TAKING ANY MEDICATION FOR THE LISTED MEDICAL CONDITIONS? IF SO, PLEASE INDICATE

NAME	DOSAGE	REASON
	/	/
	/	/
	/	/
	/	/

➢ ***I attest to the accuracy of this information:*** **Initials:_____ Date:_____**

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

FINANCIAL GUIDELINES

- ✓ **PAYMENT METHODS:** We gladly accept *all* major credit cards, cash and various financing options with CareCredit® and LendingClub®
- ✓ **WE ARE A FEE FOR SERVICE** This means you are responsible for all payments to Northside Dental at the time of service.
- ✓ **INSURANCE:** If you have insurance, it is your responsibility to know your insurance plan details and no estimate is a guarantee for payment. 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.

SHORT CANCEL / NO SHOW APPOINTMENTS / UNPAID BALANCES / APPOINTMENT CONFIRMATIONS

- We politely ask for **2-business days** for any changes or cancellations, so that we may give that reserved time to another patient in need. We understand things come up.
- There is a ***$50 *an hour**** *no show fee for ALL appointments,* if canceled less than 2 business days in advance. Please understand that patients who no-show deny several of our patients the opportunity to receive the care they need.
- 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.
- I understand that my account balance, if left unpaid, will be referred to a collection agency. I also understand that if treatment or care is suspended at any time by me the patient, all fees for professional services rendered will be due immediately.
- Please understand, to keep your dental reservation, it is the responsibility of the patient to confirm his/her appointment before the next scheduled date. Unless otherwise noted, we will have to cancel that appointment due to non-confirmation. This is to ensure that patients in need will get the continuity of care they deserve. You may confirm the appointment at the time it is scheduled.

As of right now, we have automated messages that go out for appointment reminders and we cannot change which method goes out over the other. We apologize for the inconvenience.

➢ **Signature:**_____ **Date:**_____

PLEASE FLIP OVER FOR THE BACKSIDE→

HIPPA CONSENT

- **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

    - Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

    - We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

    - You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

- **Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to Doctor Brandon Cera. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

- **Acknowledgment:** I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

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 car e of myself. This is information will only be used in proving dental care, dental claims and/or discussing treatment options with other dental professionals.

- **Signature:** _____ **Date:** _____

Please allow the following medical professionals/ people to have access to my records, including but not limited to, treatment plans, payments, appointment times and insurance questions.

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

IF EMAILING X-RAYS PLEASE EMAIL TO << Info@NorthsideDentalSantaFe.com >>

FOR OFFICE USE ONLY: *We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:*

- ☐ *Individual refused to sign*
- ☐ *Communication barriers prohibited obtaining the acknowledgement*
- ☐ *Other (please specify)*

Staff Initials_____Date_____