Northside Dental

NEW PATIENT INFORMATION

Name: _____Preferred Name: _____

Date of Birth: _____ SSN: _____

Street Address: _____

City, State, Zip:_____ *E-mail*:_____

Cell Number: _____Home Number: _____ Other: _____

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

EMERGENCY CONTACT INFORMATION

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

DENTAL INSURANCE INFORMATION

Subscriber Name: _____DOB: _____SSN: _____

Insurance Carrier: _____ ID Number: _____

Group Number: _____ Carrier Phone #: _____

PREVIOUS DENTIST INFORMATION

Dentist Name: _____*Phone:* _____

Reason for change: ***Permission to Request X-rays? Yes/ No***

ALLERGIES:

__Dental Anesthetic __Aspirin __Acetaminophen __Barbiturates __Codeine __Ibuprofen __Latex __Metal __Penicillin __Sulfa Other:_____

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

- ☐ History of Gum Disease/Deep Cleaning
- ☐ History of Addiction __Drugs __Alcohol
- ☐ History of Tobacco Use
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Artificial Joints Date Placed: _____
- ☐ Asthma
- ☐ Blood Disease/ Clotting problems
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cancer- Type_____
- ☐ Chemotherapy/Radiation Therapy
- ☐ Diabetes
- ☐ Depression
- ☐ Dizziness/ Fainting
- ☐ Emphysema
- ☐ Epilepsy/ Seizures
- ☐ Frequent Ear/headaches
- ☐ Heart Disease
- ☐ Hepatitis Type: _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Sinus Trouble
- ☐ History of Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ **Other:**

_____

_____

___ **NONE**

MEDICATION NAME	**DOSAGE**	**REASON**

➢ **Signature:** _____ **Date:** _____

FINANCIAL GUIDELINES

- ✓ **PAYMENT METHODS:** We gladly accept *all* major credit cards, cash and various financing options with CareCredit® and LendingPoint®
- ✓ **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.

APPOINTMENT GUIDELINES

- 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.
- There is a ***$50 per hour*** *no show fee for ALL appointments,* if canceled less than 2 business days in advance.
- 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.
- To reserve your dental appointment, it is the responsibility of the patient to confirm his/her appointment before the next scheduled date. Unless otherwise noted, we will reserve the right to cancel your 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.

Authorization: I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my 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, 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.

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

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 reading the black binder provided to you in the reception area.
- **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.

    - **Signature: _____ Date: _____**

**** Please allow the people listed below to have access to my records, including but not limited to, treatment plans, payments, appointment times and insurance questions****

Name: _____ Name: _____ Name: _____

RECORDS RELEASE

PLEASE READ AND SIGN: 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.

- **Print Name: _____DOB: _____**
- **Signature:_____Date:_____**

Previous Dentist Name: _____ City/State: _____

PLEASE EMAIL X-RAYS TO:

<< Info@NorthsideDentalSantaFe.com (.JPG format please) >>

PATIENT'S PERSONAL SIGN IN SHEET

	DATE	APPT TIME	TIME IN		TIME OUT	STAFF INITIALS
1				STAFF USE ONLY		
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						