NORTHERN EDGE DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ DL# _____ Gender: ◯M ◯F Married: ◯Y ◯N

Home Phone_____ Cell Phone_____Email_____

Employer_____ Work Phone_____

How did you hear about us? ☐ Google ☐ Yelp ☐ Facebook ☐ Flyer ☐ Referred by: _____

☐ Other: _____

If patient is under 18 yrs, please also complete the following:

Guarantor Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ DL# _____ Gender: ◯M ◯F Married: ◯Y ◯N

Work Phone_____ Cell Phone_____Email_____

Student status if dependent over 19 (for ins) ◯Nonstudent ◯Fulltime ◯Part time

ADDRESS AND HOME PHONE

Check circle if same for entire family: ◯

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Patient relationship to subscriber: ◯Self ◯Spouse ◯Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber: ◯Self ◯Spouse ◯Child

Subscriber Name_____Sub.ID # _____Sub.DOB_____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:_____

Please complete reverse side.

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

☐ None

_____

_____

_____

_____

Check medications or drugs you are allergic to:

- ☐ None
- ☐ Aspirin
- ☐ Codeine/ Other Narcotics
- ☐ Erythromycin
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other: _____

Check any medical conditions you may have:

- ☐ None
- ☐ AIDS/HIV
- ☐ Alcohol/Drug Abuse
- ☐ Anemia/Leukemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma/Hay Fever
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer/Tumor or Growth
- ☐ Cardiac Pacemaker
- ☐ Chest Pain Upon Exertion
- ☐ Damage Heart Valve
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells/Seizures
- ☐ Fever Blisters/Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth/Sjogren
- ☐ Gall Bladder Trouble
- ☐ Heart Attack/Stroke
- ☐ Heart Disease/Angina
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ Hives/Skin Rash
- ☐ Joint Replacement, Date of: _____
- ☐ Kidney/Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other: _____

WOMEN ONLY - Are you pregnant or do you have reason to believe you may be? ☐ Yes / ☐ No

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?

_____

Reason for today's visit:_____ Are you in pain? Yes ☐ / No ☐

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Name (printed) Date

_____

Patient/Guardian Signature

FINANCIAL AGREEMENT

1. I agree to pay all fees that are due and outstanding for services rendered. *Initials*:_____

2. Every effort will be made to help me with my coverage for dental procedures under my dental insurance. Although Northern Edge Dentistry may provide an estimate of my insurance benefits and how much my insurance is expected to pay, I understand that that Northern Edge Dentistry is not responsible for the accuracy of this estimate of coverage. *Initials*:_____

3. Regardless of the estimate provided of my dental benefits, I agree that if my dental insurance does not pay as estimated, **I will be responsible for all charges not paid by my insurance company regardless of the reason for nonpayment.** *Initials*:_____

4. Not all services that Northern Edge Dentistry provides are covered benefits. I understand that benefits differ by dental plans. Fees for non-covered services along with deductibles and copays are due at the time of service. *Initials*:_____

5. I agree to notify this office if I need to cancel or reschedule my appointment at least **24 hours** prior to my scheduled appointment date. *Initials*:_____

6. If I cancel or reschedule my appointment within 24 hours of my scheduled appointment date, or if I fail to show up to my scheduled appointment without providing notice, I agree to pay a **$25 cancellation fee**. *Initials*:_____

7. I understand that Northern Edge Dentistry reserves the right not to schedule future appointments if the following happens more than twice: (1) I cancel or reschedule my appointment within 24 hours of my original appointment time; or (2) I fail to show up to my appointment without providing notice. *Initials*:_____

8. Every effort will be made by this office to see patients at their scheduled appointment times. I understand that if I am more than 15 minutes late to a scheduled appointment, my appointment may be rescheduled. *Initials*:_____

9. If my bill is sent to collections, I agree to pay a **$30 collection fee**, all related fees and court costs. *Initials*:_____

By signing below, I certify that I have read this financial agreement, and that I understand and agree to it.

_____
Patient/Guardian Name (printed)

_____ _____
Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is In effect. This Notice takes effect (10/13/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in **writing** to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $2.00 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alterative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alterative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

[

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I,_____, have received a copy of this office's Notice of
Name of Patient (or parent if under 18 years)
Privacy Practices.

_____
Patient Name (printed)

_____
Signature of Patient (or parent if under 18 years)

_____
Date

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
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)