REGISTRATION

Name: _____ Date of Birth: _____

Preferred Name _____Email Address_____

Phone Number: _____Social Security No. _____

Address: _____

City: _____State: _____Zip: _____

Mark appropriate box: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer_____

Spouse's Full Name: _____ Date of Birth_____

Spouse's Employer: _____

If a Minor:

Father's Full Name: _____

Mother's Full Name: _____

Name of person responsible for account: _____

Emergency Contact_____**Number**_____

DENTAL INSURANCE INFORMATION:

Primary

Dental Insurance Company: _____

Employer: _____ Policy Holder: _____

DOB:_____PolicyID#_____Group #: _____

Secondary

Dental Insurance Company: _____

Employer: _____ Policy Holder: _____

DOB:_____PolicyID#_____Group #: _____

Whom may we thank for this referral? _____

I hereby authorize the staff of this office to perform those dental procedures necessary to accomplish this agreed-to-treatment. (Provided the benefits, alternatives, discomforts and risks will be explained to me and that my special consent will be obtained for procedures with potentially serious complications.)

Signature (Parent or Guardian if a minor)_____ Date:_____

NorthwayDental associates

Office Use Only:
Account #: _____
Reviewed By:_____

Patient Health History

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Date of Birth: / /	Gender:	
Home Phone:	Cell Phone:	
Address:	City:	State: Zip:
Employer:	Occupation:	

Preferred Contact Method:
☐ Call (_____)_____
☐ Text (_____)_____
☐ Email _____

NEW PATIENTS ONLY:
Prior Dentist/Clinic Name: _____
Last Dental Exam:_____

	Yes	No
Do you use vaping products?	☐	☐
Do you smoke or use tobacco products?	☐	☐
Do you use controlled substances for either medical or recreational reasons?	☐	☐

WOMEN ONLY: Are you?	Yes	No
Taking birth control pills?	☐	☐
Nursing?	☐	☐
Pregnant?	☐	☐
If yes, number of weeks _____		

ALLERGIES Please use an "X" to mark your answers.

To all "YES" responses, specify reaction.	Yes	No	?
Aspirin _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Erythromycin _____	☐	☐	☐
Hay fever/seasonal allergies _____	☐	☐	☐
Latex (Rubber) _____	☐	☐	☐

	Yes	No	?
Local anesthetics _____	☐	☐	☐
Metals _____	☐	☐	☐
Penicillin _____	☐	☐	☐
Sulfa Drugs _____	☐	☐	☐
Other _____	☐	☐	☐

DENTAL HISTORY Please use an "X" to mark your answers.

	Yes	No
Do your gums bleed when you brush or floss your teeth?	☐	☐
Have you ever had periodontal (gum) treatments like scaling and root planing?	☐	☐
Does your jaw click, pop or hurt?	☐	☐
Do you clench or grind your teeth?	☐	☐
Have you ever experienced any of these sleep-related breathing disorders?	☐	☐

☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Are you happy with your smile?	☐	☐

If not, why? Please mark all that apply:
☐ Color of teeth ☐ Shape of teeth ☐ Position of teeth
☐ Other. Please describe: _____

MEDICAL AND SURGICAL HISTORY Please use an "X" to mark your answers.

	Yes	No
Has a physician or previous dentist ever recommended that you take antibiotics prior to dental work?.	☐	☐
Have you had a serious illness, operation or been hospitalized in the last 5 years?	☐	☐
If yes, what? and when? _____		
Have you had any joint replacement surgery?	☐	☐
If yes, what? and when? _____		
Have you had a heart valve replacement or heart surgery?	☐	☐
Have you had an organ or bone marrow/stem cell transplant?	☐	☐

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers.

	Yes	No	?
Heart (Cardiac) Health			
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Pacemaker/implanted defibrillator	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
If yes, date: _____			
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy	☐	☐	☐
Radiation treatment	☐	☐	☐
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
Hemophilia	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Brain (Neurological) / Mental Health	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury	☐	☐	☐
Stroke	☐	☐	☐
If yes, date: _____			

	Yes	No	?
Autoimmune Disease			
AIDS or HIV infection	☐	☐	☐
Lupus	☐	☐	☐
Digestive Health			
Gastrointestinal disease	☐	☐	☐
Reflux/persistent heartburn (GERD)	☐	☐	☐
Other			
Arthritis/Rheumatoid Arthritis	☐	☐	☐
Glaucoma	☐	☐	☐
Diabetes	☐	☐	☐
If yes (circle): Type I Type II			
Eating Disorder	☐	☐	☐
Hepatitis, jaundice, liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Sexually Transmitted Infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

MEDICATIONS

	Yes	No
Are you taking any **blood thinners**? *(such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin).*	☐	☐
If yes, what?_____		
Are you taking or have you taken any medication to treat **osteoporosis** or Paget's disease? *Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).*	☐	☐
If yes, what?_____ How many years have you been taking it? _____		
Are you taking, or have you taken, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? *Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).*	☐	☐
If yes, what?_____ How many years have you been taking it? _____		
Are you taking any weight loss medications? If yes, what? _____	☐	☐

Please list all medications below. If you have a long med list that can be scanned, please give a printed copy to the front desk.

MEDICATION	Why are you taking it?	How often do you take it?

By signing below, I certify I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient / Legal Guardian:_____ Date: _____

FOR OFFICE USE ONLY:

Provider Signature: _____ Date: _____

NORTHWAY DENTAL ASSOCIATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 our 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 protective 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.

Right to Revoke: You will have the right revoke this Consent at any time by giving us written notice of our revocation submitted to Northway Dental. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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 health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Medical Information Release Form

(HIPAA Release Form)

Full Name: _____ Date of Birth: ___/_____/_____

Release of Information

I authorize the release of information including diagnosis records, examination rendered to me and claim information. This information may be released to the person(s) below:

[ ] Spouse: _____

[ ] Child (ren): _____

[ ] Parent(s): _____

[ ] Other: _____

[ ] I choose **not** to have my information to be released to anyone.

This Release of Information will remain in effect until terminated by patient in writing.

Contact Information for Patient

Please contact me by:

[ ] Cell Phone: _____

[ ] Home Phone: _____

[ ] Work Phone: _____

If you are unable to reach me:

[ ] You may leave a detailed message at the above number

[ ] You can text a detailed message to my cell phone

[ ] Do **not** leave a detailed message, I will return your call

Signed: _____ Date: _____/_____/_____

NORTHWAY DENTAL FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to treatment.

GENERAL:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:

There may be a fee for appointments broken without 24 hours' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. Please help us service you better by keeping scheduled appointments

INSURANCE:

Your insurance is a contract between you and your insurance company/employer; therefore, all charges are your responsibility. As a courtesy to you, we will file your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have questions about fees for planned services it is your responsibility to have those questions answered prior to treatment.

We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

PAYMENT:

Full payment is due at the time of service. If insurance benefits apply, estimate patient co-payments and deductibles are due at the time of service unless other arrangements are made.

We offer the following payment options: Cash, Check, HSA, Visa, and some major credit cards.

Unpaid balance over 30 days from date of statement will be subject to monthly interest of 1.5%. If payment is delinquent, you will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy shall also cover your dependent children who are patients of the practice.

Patient's Name: _____

Signature:_____ Date: _____

NorthwayDental associates

Signature on File

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. (Northway Dental will be assigned payment benefits and will then apply that amount to your account.)

Printed Name: _____ Date: _____

Signature:_____