REGISTRATION

Please complete all information below.

Name: ____ Date of Birth: _________________________________

Preferred name if different from above: ____

Cell Phone: _________________ Home Phone: ___________________ Social Security No.__________________________

Email Address: ____

Home Address: ____

City: _____________________________________ State: __________________ Zip Code: ______________________________

Please Check Appropriate Box: □ Child □ Single □ Married □ Divorced □ Widowed □ Separated

Present Employer: __________________________ Position: ____________________ Work Phone: ______________________

Spouse's Full Name: ____

Spouse's Employer: ______________________ Position: ___________________ Work Phone: ________________________

If for child or teen under 18, please list:

Father's Full name: ____

Father's Employer: ____ Work Phone: __________________________________

Mother's Full Name: ____

Mother's Employer: ____ Work Phone: _________________________________

Children in family (name and age):

____ ____

All accounts are due 30 days from the date of service. Balances not clear within 60 days are subject to an annual rate of 8%. Please feel free to discuss your account with our business office at any time.

Name of person responsible for account: ____

Name of any person allowed to receive information about your dental care (ex. Parent, Spouse, Guardian): **Age 18+**

____

Name and phone number of two people whom we may contact in care of an emergency:

____ ____

DENTAL INSURANCE INFORMATION:
Please list ALL dental insurance carriers (especially if you have dual coverage and Medical Assistance)

1. __________________________ ☐ Self ☐ Spouse ☐ Parent
2. __________________________ ☐ Self ☐ Spouse ☐ Parent

Whom may we thank for this referral? ____

☐ Online ☐ Walk in ☐ Other Source

I hereby authorize the staff of this office to perform those dental procedures necessary to accomplish this agree-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: ____________________

Account #__________

Patient Health History

PATIENT'S NAME: ____

Last First MI Date of Birth

____

Prior Dentist/Clinic Name **(New Patients only)** City/State Last Dental Exam

____

Physician Name Medical Clinic Name Last Physical Exam

Allergies- Select all that apply:

[ ] Aspirin Allergy [ ] Codeine Allergy [ ] Erythromycin Allergy [ ] Hay Fever

[ ] Latex Allergy [ ] Local Anesthetic Allergy [ ] Metal Allergy [ ] Penicillin Allergy

[ ] Sulfa Allergy [ ] Other Allergy: ____

MEDICATIONS – Please list all medications you are currently taking:

____

____

____

____

____

____

Have you had any serious illnesses or surgeries? (Describe) ____

____

Are you currently Pregnant or Nursing? ( ) Yes ( ) No

Are you Using Birth Control Pills? ( ) Yes ( ) No

Do you smoke or use tobacco products? ( ) Yes ( ) No

Do you habitually use controlled substances? ( ) Yes ( ) No

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DO YOU HAVE OR HAVE YOU EVER HAD: (check all that apply)

( ) Cardiovascular Disease/ Angina
( ) Heart Pacemaker/Defibrillator
( ) Heart Murmur
( ) Artificial (Prosthetic) Heart Valve
( ) Congenital Heart Disease (CHD)
( ) Previous Infective Endocarditis
( ) Asthma
( ) Blood Disease
( ) Anticoagulants
( ) High Blood Pressure
( ) Low Blood Pressure
( ) Stroke
( ) Gastrointestinal Disease
( ) Kidney Disease
( ) Liver Disease
( ) Thyroid Problems
( ) Diabetes
( ) Arthritis/Rheumatoid Arthritis
( ) Autoimmune Disease
( ) Artificial Joints
( ) Osteoporosis/Osteopenia
( ) Cancer
( ) Tumors
( ) Chemotherapy/Radiation Treatment
( ) Epilepsy
( ) Hepatitis
( ) Tuberculosis
( ) Glaucoma
( ) Herpes
( ) Sexually Transmitted Disease
( ) HIV or AIDS
( ) Mental Health Disorder
( ) Other conditions not noted____________________

____

____

____

COMMENTS:

____

____

____

By signing this form, I certify that the above information is true and correct to the best of my knowledge.

____
Patient or Legal Guardian Signature Date

____
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 your 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 Notices, at any time.

Right to revoke: You will have the right to revoke this Consent at any time by giving us a written notice of our revocation submitted to Northway Dental Associates. 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.

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 written consent to you to 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: ________________