NorthStar Dental
Greeley

New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us – we will be happy to help!

How did you hear about us? _____

ABOUT YOU

Name:_____ I prefer to be called_____ [ ]Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other **DOB:**____/____/_____ Age:____ **S.S. #**_____

Home Address: _____City_____State_____Zip_____

Home Phone: (___)_____ Work: (___)_____Ext.___ Cell: (___)_____

E-Mail Address:_____

Employer:_____ How Long There?_____ Occupation:_____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as Above

Name:_____ Birth Date:____/____/_____ Relation:_____

Billing Address: _____City_____State_____Zip_____

Home Phone: (___)_____ Work: (___)_____Ext.___ S.S. #_____

Employer:_____ How Long There?_____ Occupation:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Birth Date:____/____/_____ Relation:_____

Employer:_____Home Phone: (___)_____ Work: (___)_____Ext.___

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name_____ Phone: (___)_____ Group #_____

Insured's Name: _____ Insured's Birthdate: ____/____/____ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name_____ Phone: (___)_____ Group #_____

Insured's Name: _____ Insured's Birthdate: ____/____/____ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (___)_____

Do you have any of the following? Please check all that apply:

[ ] Allergies/Hay Fever	[ ] Fever Blisters/Cold Sores	[ ] Osteoporosis
[ ] Anemia	[ ] Frequent Cough	[ ] Radiation Treatment
[ ] Angina	[ ] Glaucoma	[ ] Respiratory Problems
[ ] Arthritis	[ ] Heart Disorder*	[ ] Rheumatic Fever
[ ] Artificial Joints*	[ ] Heart Infection*	[ ] Rheumatism
[ ] Artificial Heart Valves*	[ ] Heart Murmur	[ ] Sickle Cell Disease
[ ] Asthma	[ ] Heart Pacemaker	[ ] Sinus Problems
[ ] Breathing Problems	[ ] Heart Surgery*	[ ] Stroke
[ ] Cancer	[ ] Hepatitis – Type ( )	[ ] Surgical Shunt*
[ ] Chemical Dependency	[ ] High Blood Pressure	[ ] Thyroid Problems
[ ] Chemotherapy	[ ] HIV/AIDS	[ ] Tuberculosis
[ ] Diabetes	[ ] Kidney Problems	[ ] Ulcers
[ ] Epilepsy or Seizures	[ ] Liver Problems	[ ] Venereal Disease
[ ] Excessive Thirst	[ ] Mental Disorders	[ ] Yellow Jaundice
[ ] Fainting or Dizziness	[ ] Mitral Valve Prolapse	[ ] Other_____

*This condition may require antibiotic pre-medication for certain dental procedures.

YES NO

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

[ ] [ ] Are you currently under the care of physician?
If yes, explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past 2 years?
If yes, explain: _____

[ ] [ ] Are you taking any medications or herbals?
If yes, list: _____

[ ] [ ] Are you **allergic** to any medications or substances?
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other _____

[ ] [ ] Have you used tobacco? If yes, explain: _____
[ ] [ ] Have you used marijuana? If yes, explain: _____
[ ] [ ] Have you used vape pens/electronic cigarettes? If yes, explain: _____

WOMEN {Check}: [ ] Pregnant # Weeks____ [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X_____ Date_____
Signature of patient, parent or guardian

X_____ Date_____
Signature of treating Doctor

DENTAL HEALTH QUESTIONNAIRE

*We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan.

*We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there.

*We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together. Please help us better understand your dental health needs and goals by answering the following questions. (Check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? [ ] **Yes** [ ] **No**
2. I have a [ ] **Low** [ ] **Moderate** [ ] **High** fear of going to the dentist.
3. My mouth and teeth are [ ] **Very** [ ] **Moderately** [ ] **Not** comfortable.
4. I am [ ] **Very Satisfied** [ ] **Satisfied** [ ] **Dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **Excellent** [ ] **Good** [ ] **Fair** [ ] **Poor**
6. Do you have discomfort in your jaw? (TMJ) [ ] **Yes** [ ] **No**
7. Have you ever been interested in braces? _____
8. Are you interested in a whiter smile? [ ] **Yes** [ ] **No**
9. Do you snore? [ ] **Yes** [ ] **No**
10. Have you been diagnosed with sleep apnea? [ ] **Yes** [ ] **No**
11. Do your gums bleed? [ ] **Yes** [ ] **No**
12. Have you ever been told you have gum disease? [ ] **Yes** [ ] **No**
13. Are your teeth sensitive to any of the following?

    _____**Heat** _____**Cold** _____**Sweet** _____**Pressure**

14. I would say that my main concerns with my dental health are:

    _____

15. Previous Dentist: _____

    Date of Last visit: _____

    Reason for leaving: _____

    Qualities you like in a dentist: _____

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time or slightly early because each appointment is time reserved just for you. Please make every effort not to change your scheduled appointment. If you must change your appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Missed appointments are subject to a charge of a minimum of $110.00.

FINANCIAL POLICY

Unless other financial option is PRE-ARRANGED, payment is due in full the day of treatment. If we are submitting claims to insurance, the ESTIMATED portion and the deductible will be the amount due. After insurance pays their portion, if there is still any amount owed, that is then the patient's responsibility and a billing statement will be mailed to the patient. To avoid confusion, statements are not sent until ALL insurance payments are received. For patients that have insurance plans that pay the insured patient directly, the full amount will be due to us at time of service.

Payment options:

1. For your convenience we accept Cash, Check, Visa, Mastercard, Amex and Discover
2. Care Credit is a payment option that we also accept – please ask if you are interested in this option

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs is your responsibility to know and is a contract between you and your insurance company. We bill your insurance directly as a courtesy.

Finance Charges and Fees
*Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% Annual)
*Returned checks are subject to a $30 accounting fee.

I have read and agree to the above

Printed Name: _____

Signature: _____ Date: _____

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to dental examination by the Doctor. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Communication Consent

I authorize NorthStar Dental to use my contact information that I provided in this document to reach me for appointment reminders, billing inquiries, appointment feedback, and any other communications pertaining to services provided at this facility. I understand that I may choose to opt-out at any time by contacting NorthStar Dental.

Release of Information

I authorize my Doctor to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professions.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to my Doctor.

Photography Release

I authorize my Doctor to take photographs of my teeth when necessary to help me better understand my current dental condition and possible treatment options.

I understand and will comply with the office **Appointment Policy.**
I understand and will comply with the office **Financial Policy.**
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken for my benefit in the Doctor deems it necessary.

X_____Date_____
Signature of patient, parent or guardian

HIPAA

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, e.g. my insurance company
- The day to day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these request restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to Patient: _____

Date: _____

Signature: _____

I authorize my medical information and records to be shared with:

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