PATIENT REGISTRATION FORM

Patient's Name:____
(Last) (First) (M.I.) (Mr., Mrs., Ms., Dr.)

Check one: _____ child _____ single _____ married _____ widowed _____ divorced
Age:________ Date of Birth:_____/_____/_____ SS#:______________________________
Mailing Address:______________________________ City/State/Zip:____________________

(To respect your privacy, please ONLY list the phone number(s) where we may call you.)
Home Phone:________________ May we leave a message on voice mail? _____ Yes _____ No
Work Phone:________________ May we leave a message on voice mail? _____ Yes _____ No
Cell Phone:________________ May we leave a message on voice mail? _____ Yes _____ No

E-Mail:______________________________ Student? _____ Yes _____ No P/T F/T
Employed By:______________________________ Occupation:____________________

Name of Spouse:______________________________ Employer:____________________
Age:________ Date of Birth:_____/_____/_____ SS#:____________________

Previous Dentist:______________________________ Address:____________________
Approximate Date of Last Thorough Dental Exam:____________________

How did you hear about us?
_____ Referred by:____________________ _____ Website _____ Location _____ Phone Book
_____ Other:____________________ _____ Newspaper _____ Facebook _____Google

****

~PRIMARY INSURANCE~

Insurance Company:____________________ Employer:____________________
Insurance Phone #:____________________ Group #:____________________
Address to Submit Claims:____
Policyholders' Name:____________________ Relationship to Patient:____________________
Policyholders' Address:____
Policyholders' SS# or ID#:____________________ Date of Birth:_____/_____/_____

~SECONDARY INSURANCE~

Insurance Company:____________________ Employer:____________________
Insurance Phone #:____________________ Group #:____________________
Address to Submit Claims:____
Policyholders' Name:____________________ Relationship to Patient:____________________
Policyholders' Address:____
Policyholders' SS# or ID#:____________________ Date of Birth:_____/_____/_____

I understand that my dental insurance is a contract between the insurance carrier and me, and **not** between the insurance carrier and True North Dentistry. **I understand that I am fully responsible, regardless of benefits, for all dental fees at the time of service unless prior arrangements have been made with the office.** Any balance due past the end of the month may be subject to a finance charge computed at 2% per month. I agree to pay all costs and expenses incurred should this account be turned over to an attorney, collection agency, including attorney fees, collection agency fees & court costs. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. If there is an open balance, a statement will be sent to you.

Printed Name:____________________ Signature:____________________
Date:____________ (Parent or Guardian Signature is required if patient is a minor: under 18 years of age)

MEDICAL HISTORY FORM

Date________________

Name____ Date of Birth___/___/___ Sex M F
Last First Middle mo day yr

For the following questions, *circle yes or no*, which ever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may additional questions concerning your health.

1. Are you in good health?........ Yes No
2. Has there been any change in your general health within the past year?........ Yes No
3. Date of last physical examination________________
4. Are you now under the care of a physician?........ Yes No
   If so, what is the condition being treated?________________
5. The name and address of your physician(s)________________
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?........ Yes No
   If so, what was the illness or problem?________________
7. Are you taking any medicine(s) including non-prescription medicine?........ Yes No
   List medications________________

8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease........ Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)........ Yes No
      1. Do you have chest pain upon exertion?........ Yes No
      2. Do you have heart defects?........ Yes No
      3. Do you have cardiac pacemaker........ Yes No
   c. Do you require premedication before dental trmt due to your cardiovascular disease or joint replacement surgery? Yes No
   d. Sinus trouble........ Yes No
   e. Asthma or hay fever........ Yes No
   f. Fainting spells or seizures........ Yes No
   g. Persistent diarrhea or recent weight loss........ Yes No
   h. Diabetes........ Yes No
   i. AIDS or HIV infection........ Yes No
   j. Respiratory problems, emphysema, bronchitis, etc........ Yes No
   k. Arthritis or painful swollen joints........ Yes No
   l. Stomach ulcer or hyperacidity........ Yes No
   m. Kidney trouble........ Yes No
   n. Tuberculosis........ Yes No
   o. Persistent swollen glands in neck........ Yes No
   p. Low blood pressure........ Yes No
   q. Sexually transmitted disease........ Yes No
   r. Epilepsy or other neurological disease........ Yes No
   s. Problems with mental health........ Yes No
   t. Cancer........ Yes No
   u. Problems of the immune system........ Yes No
9. Have you had abnormal bleeding?........ Yes No
10. Do you have any blood disorder such as anemia?........ Yes No
11. Have you ever had any treatment for a tumor or growth?........ Yes No
12. Have you ever taken any diet medication such as Phen/Fen?........ Yes No
13. Are you allergic or have you had a reaction to:
    Local anesthetic........ Yes No
    Penicillin or other antibiotics........ Yes No
    Sulfa drugs........ Yes No
    Barbiturates, sedatives, or sleeping pills........ Yes No
    Aspirin........ Yes No
    Iodine........ Yes No
    Codeine........ Yes No
    Latex – Dental materials or solutions – if so, explain________________ Yes No

Please list any other allergies not listed_______________

14. Have you had any trouble associated with any previous dental treatment? .... Yes No
    If so, explain_______________
15. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
    If so, explain_______________
16. Have you ever taken medication for Osteoporisis? .... Yes No
17. a. Do you use tobacco? .... Yes No
    b. Do you use cocaine or other drugs? .... Yes No
    c. Do you use alcohol? .... Yes No
       If so, how often?_______________
    d. Have you ever been treated for alcoholism or chemical dependency? .... Yes No
    e. Do you use a vape of any kind? .... Yes No
18. Do you snore or has anyone ever told you that you snore? .... Yes No
19. Has anyone reported that you gasp for air, choke, or stop breathing while you sleep? .... Yes No
20. Have you previously been diagnosed with Sleep Apnea? .... Yes No

Women (#21-#23)

21. Are you pregnant? .... Yes No
    If so, what is your due date?_______________
22. Are you nursing? .... Yes No
23. Are you taking birth control pills or using Norplant implants or similar devices? .... Yes No

Check (x) if you have had problems with any of the following

___ Bad Breath
___ Bleeding gums
___ Clicking or popping
___ Food collection between teeth
___ Grinding or clenching teeth
___ Loose or broken fillings
___ Periodontal treatment
___ Snoring or sleep apnea
___ Sensitivity to hot or cold
___ Sensitivity to sweets
___ Sensitivity when biting
___ Sores or growths in your mouth

How often do you floss?_______________ How often do you brush?_______________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the periods of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

X_______________

Signature of patient or parent if minor

For completion by the Dentist

Comments on patient interview concerning medical history:_______________

_______________ (Date)

_______________ (Signature of Dentist)

PAYMENT:

Please be prepared to **remit payment** in full for your services at the time of your appointment. For your convenience, we accept all major credit cards, cash and checks. We gladly extend a 5% discount for patients who wish to pay in full for services with cash or check.

INSURANCE:

Please note that we are **not a contracted provider** for your insurance company. We will calculate and estimate benefits at the time of your appointment and request that you **remit full payment** for your estimated portion at that time. We will gladly submit a claim to your insurance and carry that portion of the balance for a reasonable duration. After your insurance claim has been paid on, we will send you a statement for any remaining balance. Any overage can be applied to another visit or issued back to you upon your request. Please be aware that some insurance companies will only remit payment to the patient. We do participate with a dental creditline company. If you wish to use this option to carry your balance, please contact our office for an application.

Patient Name: ______________________________

Patient Signature: ______________________________

Date: ______________

~Personal Dental Needs Survey~

*NAME:______________________________________ DATE:___________

Please rank, in order of importance, each of the following regarding your dental care. (The most important would be #1, and the least important would rank #5)

___ Preventive dental health care
___ Excellence and quality of service
___ Other______________________
___ Freedom from pain
___ Cost and affordability

Please rank, in order of importance, what a dentist has to do to gain your confidence. (The most important would be #1, and the least important would rank #3)

___ Show me what he is doing or needs to do so I can clearly understand what is happening.
___ Listen to my concerns and explain thoroughly the procedures to be performed.
___ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have about your dental visits. (10 being the greatest fear)

1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit. (Check all that apply)

___ Nitrous Oxide
___ Sedative Medications (Valium)
___ Patient Education Materials

Are you concerned about the following? (Yes or No):

___ Existing discomfort?
___ Replacing old mercury-silver amalgam fillings?
___ Recurring or untreated gum disease?
___ Mouth odor?
___ Whitening your teeth?
___ Appearance of your smile? (Cosmetics)
___ Prevention of decay?
___ Other _________________________

Given my past experience, I expect to keep my natural teeth until I am _____ years old.

When discussing my treatment plan, I prefer. . . (Circle One)

THE BIG PICTURE DETAIL BY DETAIL

Is there anything else that you think we should know about your care and treatment in our office?

____
____
____
____

Thank you for taking the time to assist us in getting to know you.
We look forward to a long and happy professional relationship!

TRUE NORTH DENTISTRY

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 INFORMATION IS IMPORTANT TO US

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, or to family and friends you approve.

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. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

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 or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

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. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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 alternative 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 with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PRIVACY PRACTIVES ACKNOWLEDGMENT

Privacy Notice September 2024

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use of my Personal Health Information.

______________________________	______________________________	______________
Patient Name (printed)	Patient Signature	Date

______________________________	______________________
Practice Witness	Date