Northbrook Dental Care

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Date: _____

PATIENT INFORMATION

Name – First: _____ Last: _____
Birth Date: _____ SSN: _____ ☐Single ☐Married ☐Child
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ ☐Cell ☐Home
Email: _____
Emergency Contact: _____ Phone #: _____
Person Responsible for Account: _____

DENTAL INSURANCE INFORMATION

☐No Dental Insurance

Insurance Company: _____ Phone #: _____
Insurance ID#: _____ Group #: _____
Name of Insured: _____ Birth Date: _____
SSN: _____ Relationship to Patient: _____

PATIENT DENTAL HISTORY

Name of Previous Dentist: _____ Last Exam: _____

Reason for your dental visit today? _____
_____

Do you have any dental problems or concerns? ☐Yes (Please List Below) ☐No
_____
_____
_____

PATIENT MEDICAL HISTORY

Physician: _____ Last Exam: _____

Are you allergic to any of the following?

- ☐Amoxicillin
- ☐Aspirin
- ☐Barbiturates
- ☐Iodine
- ☐Latex
- ☐Local Anesthetics
- ☐Penicillin
- ☐Seasonal
- ☐Sedatives
- ☐Sulfa Drugs
- ☐Other: _____

Any medications you are currently taking?

☐Yes (Please List) ☐No

_____

_____

_____

Do you/have you used the following?

☐Tobacco ☐Vape ☐Cigars ☐Cannabis

Do you have any of the following?

- ☐Arthritis
- ☐Asthma
- ☐AIDS/HIV
- ☐Cardiac Pacemaker
- ☐Cancer
- ☐Diabetes
- ☐Hay Fever
- ☐Heart Disease
- ☐Heart Murmur
- ☐High Blood Pressure
- ☐Joint Replacement
- ☐Low Blood Pressure
- ☐Mitral Valve Prolapse
- ☐Radiation Therapy
- ☐Sexually Transmitted Disease
- ☐Stomach Ulcers
- ☐Thyroid Problem

Do you/have you ever taken bisphosphates?

☐Reclast ☐Boniva ☐Fosamax

WOMEN ONLY-

☐Pregnant ☐Nursing ☐Oral Contraceptives

OFFICE FINANCIAL POLICY

For patients with no dental insurance:

It is customary for us to receive full payment for services rendered at the time of your appointment. When extensive treatment is planned that require multiple appointments, split payments may be available.

For patients with dental insurance:

Most dental benefit plans are only designed to cover a portion of the treatment. We ask for your co-payment at the time of service. Any cost that dental insurance does not cover will be the patient's responsibility.

Cancellations/Missed Appointments:

If you are unable to keep a scheduled appointment, we appreciate a 48-hour notice. For appointments cancelled with less than a 12-hour notice or a no call no show, we reserve the right to charge a missed appointment fee. Please note: Fees for missed appointments scheduled on a Saturday may be higher.

-I HAVE READ AND UNDERSTAND THE OFFICE FINANCIAL POLICY AND FULLY INTEND TO STAND BY THE FINANCIAL ARRANGEMENTS MADE WITH THE OFFICE.

_____

(Signature)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBLES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care provider. Examples of treatment would include crowns, fillings, teeth cleanings, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would include periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or email) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state, or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included by not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information party has requested. We will release your protected health information if requested by law enforcement official for any circumstance required by law.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ have reviewed the office Notice of Privacy Practices
(Print Name)

Signature: _____

Date: _____