NORTHRIDGE DENTISTRY, LLC
FAMILY, COSMETIC & IMPLANT

Name: _____ Preferred Name:_____
(Last) (First) (Middle)
Date of Birth: _____ Social Security: _____ Email: _____

Please Select: Male Female Family Status: Married Single Other

Address: _____
Street City State Zip
Home Ph:_____ Work: _____ Cell: _____

How would you prefer we contact you? Home Phone Cell Phone Text Email

Employer: _____ Occupation: _____

Parent/Guardian:_____ Parent/Guardian Phone: _____

Parent/Guardian DOB:_____ Parent/Guardian Address (if different) _____

Whom can we thank for referring you? _____

INSURANCE INFORMATION

PRIMARY:
Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

Relationship to Patient: Self Spouse Child Other _____

Social Security: _____

Name of Dental Insurance: _____

Contract #: _____ Group #: _____

Insurance Phone #: _____ Employer: _____

SECONDARY:

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

Relationship to Patient: Self Spouse Child Other _____

Social Security: _____

Name of Dental Insurance: _____

Contract #: _____ Group #: _____

Insurance Phone #: _____ Employer: _____

Patient Name: _____

MEDICAL HISTORY

Are you under physician's care now?_____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No Explain: _____

_____

Have you had a serious head or neck injury? ☐Yes ☐No Explain: _____

Are you taking any medications, pills or drugs? ☐Yes ☐No If yes, please explain: _____

Are you on a special diet? ☐Yes No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No Controlled Substances? ☐ Yes ☐ No

Women are you – ☐ Pregnant ☐ Nursing

Are you allergic to any of the following? ☐Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other Allergies: _____

Have you ever had any of the following? Please check those that apply.

☐ AIDS/HIV Positive	☐ Cold Sores	☐ Heart Attack/ Heart Failure	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Lung Disease	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Arthritis	☐ Dizziness	☐ Hemophilia	☐ Psychiatric Care	☐ Thyroid Disease
☐ Artificial Joints	☐ Drug Addiction	☐ Hepatitis A, B or C	☐ Radiation Treatments	☐ Tonsillitis
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Herpes	☐ Recent Weight Loss	☐ Tuberculosis
☐ Asthma	☐Excessive Bleeding	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Blood Disease	☐Fainting Spells	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Blood Transfusion	☐ Frequent Cough	☐ Hypoglycemia	☐ Rheumatism	☐ Jaundice
☐ Breathing Problems	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever	
☐ Cancer	☐ Glaucoma	☐ Kidney Disease	☐ Shingles	
☐ Chemotherapy	☐ Growth or Tumors	☐ Leukemia	☐ Sickle Cell Disease	
☐ Chest Pains	☐ Head Injuries	☐ Liver Disease	☐ Sinus Problems	

Have you ever had any serious illness not listed? Yes No If yes, please explain: _____

_____

DENTAL HISTORY

Date of last dental visit _____ How often do you brush your teeth? _____

Do your gums bleed while brushing or flossing? ☐Yes ☐ No Do you have frequent headaches? ☐Yes ☐No

Are your teeth sensitive to hot or cold? ☐Yes ☐No Do you clench or grind your teeth? ☐Yes ☐No

Do you feel pain or soreness in any teeth? ☐Yes ☐No Do you have sores or lumps in your mouth? ☐Yes ☐No

Have you ever experienced any of the following problems in your jaw?

Clicking? ☐Yes ☐No

Pain (joint, ear, face)? ☐Yes ☐No

Difficulty in opening/closing? ☐Yes ☐No

Difficult in chewing? ☐Yes ☐No

If you could easily and safely whiten your teeth would you? ☐Yes ☐No

Would you change anything about your smile? ☐Yes ☐☐ No What would you like to do? _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. A service charge of $25 will be applied for all returned checks. You are responsible and agree to pay all cost of collecting or attempting to collect, including attorney fees.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

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Non-Covered Services Policy

As your dentist, I want to provide you with your choice in dental services. There may be certain services that are not covered by your insurance company.

For the service(s) listed below you will be expected to pay the fee schedule difference. For that service(s) or pay for the service in full. For example, most dental contracts will pay for an amalgam (silver) filling on posterior teeth when a composite (tooth colored) is used. For example on crowns, you may choose a higher end porcelain/gold restoration. Any fee from the lab above the PPO or insurance plan fee schedule will be your responsibility.

In addition, procedures that are considered cosmetic are not covered by your contract and you will be responsible for payment in full. We only estimate what your insurance will pay and they always give a disclaimer when calling for information that benefits and payment are not guaranteed until a claim is received and processed.

Let me reassure you only services necessary and appropriate for you treatment and care will be performed. If you have any questions, someone in our office will be happy to assist you. Thank you for your understanding and we appreciate you choosing our office to help you with your dental health.

Composite Fillings on Posterior Teeth
Services that may not be covered as explained to the patient.

I have read your policy and agree, as indicated by my signature below, to pay for the services above that are not covered or for which payment is not allowed by my insurance contract.

_____ _____

Patient/Responsible Party Signature Date

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns please contact us.

If you believe that:

1. We may have violated your privacy rights,
2. We made a decision about access to your health information incorrectly
3. Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
4. We should communicate with you by alternative means or alternative locations.

You may contact us using the information listed below. 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 privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:

Charity Dempsey
225 McFarland Boulevard, Suite B
Northport, AL 35476

Ph: (205)345-7040
Fax: (205)345-4055

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that we describe in this Notice while it is in effect. This Notice takes effect November 1, 2008 and will remain in effect until replaced.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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.

Payment: We may use and disclose your health information for our healthcare operations. Healthcare operations included 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.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organization;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

Access: You have the right to view or obtain copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request copies by sending a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation or your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation or our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information (must be in writing). We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, (please print name) _____, have received a copy of this office's notice of privacy practices.

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____