7421 State Route 366
Huntsville, Ohio 43324
937-843-3932

Northwest FAMILY DENTAL

202 East Fifth Street
Marysville, Ohio 43040
937-642-3434

The mission of Northwest Family Dental is to provide quality dental care to each patient while educating them to total wellness and dental health. We provide a service that exceeds your expectations.

FINANCIAL POLICY

It is our commitment to deliver high quality and comprehensive healthcare in a warm, caring environment. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To better assist you with your healthcare investment, below is an outline of our financial policy.

For patients with a dental benefit, please remember that the contract is between you and your insurance carrier, not between the doctor and the insurance carrier. Treatment recommendations are always based on your unique dental needs, not by insurance limitations. Our business team would be happy to provide a complimentary benefits check. For questions regarding specific coverage issues, reference your insurance handbook or contact your insurance company

Our policy is as follows:

- All professional services are the responsibility of the patient. We will file all insurance claims via our electronic software as a courtesy to all of our patients. Your estimated balance for services will be collected the same day service is rendered. You are responsible for services not covered by your dental benefit.
- **Select insurance policies such as Delta Dental and Superior Dental remit payment to the subscriber, not Northwest Family Dental. It is the patient's responsibility to remit the check to Northwest Family Dental.**
- Payment options are:
    - Cash - includes money orders and personal checks
    - Visa, MasterCard, Discover
    - Care*Credit - a no interest payment plan (subject to credit approval)
- There will be a $30 fee for all returned checks.
- We reserve the right to apply a billing fee for delinquent accounts.

CHANGE OF APPOINTMENT POLICY

Our goal is to help you commit to all of your dental appointments in order to keep your smile healthy for the rest of your life. Please provide us with **2 business days notice** if you are unable to keep your reserved appointment time, so that others needing dental attention can be scheduled.

- We reserve the right to apply a fee for a broken appointment
- As a convenience to you, we will be happy to secure your reserved time with pre-payment
- Please assist us by providing us with the very best means of confirming your appointment

Authorization and Release of Information for Billing:

I authorize my insurance benefits to be paid directly to Northwest Family Dental. I authorize the release of any information by Northwest Family Dental to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account.

By signing below, you agree to the financial policy of Northwest Family Dental, and have fully read, understand and agree to the terms of this contract and have been offered a copy of this agreement.

_____ _____

Signature of Patient or Guardian Date

_____

Print Name

MEDICAL INFORMATION (CONTINUED)

YES/ NO

□ □ Are you in good health?

□ □ Are you currently under the care of a physician?

Physician Information: Please list all medical specialist that you see at least once a year. (Please print)

NAME ADDRESS/CITY PHONE NUMBER NAME OF SPECIALTY

_____

_____

□ □Are you taking or have recently taken any prescription or over the counter medicines?
If YES, please list. _____

□ □ Do you regularly take herbal medications or dietary supplements?
Specifically, do you take (circle all that apply):Echinacea/Feverfew/Garlic/Ginger/Ginko/Ginseng/Kava/St. John's Wort/Valerian/Vitamin E

□ □ Have you ever taken weight loss medication? If YES, have you taken the following? (circle all that apply): Fen-phen/Pondimen/Redux/Other

□ □ Have you undergone current or past osteoporosis therapy? (Examples are: Fosamax/Actonel/Boniva pill form)

□ □ Have you undergone current or past therapy to reduce high blood calcium? (Examples are intravenous Aredia, Zometa)

□ □ Are you or have you ever been addicted to a chemical substance? (Example: alcohol, prescription drugs, heroin, meth, cocaine, other)

□ □ Do you currently drink alcohol or recreational drugs?

□ □ Do you smoke or use smokeless tobacco?
If YES, what type of tobacco do you use? _____ How interested are you in quitting? Very Interested/Interested/Not Interested?

□ □ Has there been any changes in your general health within the past year?

□ □ Have you had a serious illness, operation or been hospitalized in the past five years?
If YES, please list: _____

Please mark a (√) to indicate if you have or have not ever had any of the following diseases/problems listed in the columns below.

YES/ NO	YES/ NO	YES/ NO
□ □ Autoimmune Disease	□ □ Excessive Urination	□ □ Psychiatric Care
□ □ Alzheimer's Disease	□ □ Excessive Bleeding	□ □ Renal Dialysis
□ □ Allergies/Hay Fever/Hives	□ □ Epilepsy/Seizures	□ □ Recent weight Loss
□ □ Anaphylaxis	□ □ Eating Disorder	□ □ Recurrent Infections
□ □ Anemia/ Blood Disease	□ □ Fainting Spells/ Dizziness	□ □ Rheumatism
□ □ Angina	□ □ Frequent Diarrhea	□ □ Rheumatoid Arthritis
□ □ Asthma	□ □ Frequent Headaches	□ □ Rash
□ □ Blood Transfusion	□ □ Glaucoma	□ □ Sinus Trouble
□ □ Breathing Problems	□ □ Heart Attack/Failure	□ □ Stroke
□ □ Bronchitis	□ □ Heart Murmur/Irregular Heart Beat	□ □ Sleeping Disorder
□ □ Bruise Easily	□ □ Heart Pacemaker	□ □ Shingles
□ □ Cancer/ Leukemia	□ □ Heart Trouble/Disease	□ □ Spina Bifida
□ □ Chemotherapy/ Radiation	□ □ High/Low Blood Pressure	□ □ Swelling of Limbs
□ □ Chest Pains	□ □ HIV/AIDS	□ □ Sickle Cell Disease
□ □ Cold Sores/ Fever Blisters	□ □ Hemophilia/Bleeding Problems	□ □ SLE (Lupus)
□ □ Congestive Heart Failure	□ □ Hepatitis A, B or C (circle type)	□ □ Spleen Removed
□ □ Cardiovascular Disease	□ □ Herpes	□ □ Steroid Therapy
□ □ Chronic/ Frequent Cough	□ □ Hypoglycemia	□ □ Stomach/Intestinal Disease
□ □ Convulsions	□ □ Impairment of Speech/Sight/Hearing	□ □ Tonsillitis
□ □ Cortisone Medicine	□ □ Kidney Problems	□ □ Tuberculosis
□ □ Diabetes	□ □ Liver Disease/Yellow Jaundice	□ □ Tumors/Growths
□ □ Damage Heart Valve	□ □ Mitral Valve Prolapse	□ □ Ulcers
□ □ Easily Winded	□ □ Pain in jaws or joints	□ □ Venereal Disease

Please complete the Health History Form and then sign below:

Northwest Family Dental request this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside of the Northwest Family Dental office will be provided this information unless authorized by you or required by law. Failure to provide the requested information will limit the ability to access your needs and may result in Northwest Family Dental being unable to accept you as a patient. By signing below, you agree that this information given is accurate and that you will notify Northwest Family Dental at subsequent appointments if there are changes in your health.

Patient/ Guardian Signature: _____ Date: _____

Dentist Signature & Date: _____ Date: _____

Patient Name:

Northwest FAMILY DENTAL

Welcome! So that we may provide you with the best possible care.
Please complete both sides of this dental/ medical history form.
All information is completely confidential.

DENTAL INFORMATION

What is the reason you are seeking dental care? _____

Please list your PREVIOUS dental provider below:

_____
(Name) (Address) (Phone Number)

Date of your: last: dental cleaning & exam _____ Full mouth series of x-rays _____

Please answer the following questions by marking an (√) in the columns provided.below

YES/NO

- □ □ Are you happy with your smile?
- □ □ Would you like your teeth to be whiter?
- □ □ Are your teeth sensitive to hot/cold/sweets/ pressure?
- □ □ Do your gums bleed when you brush or floss?
- □ □ Does food/floss get caught between your teeth?
- □ □ Is your mouth dry?
- □ □ Do you get sores or ulcers in your mouth?
- □ □ Do you participate in recreational activities?
- □ □ Do you wear a mouth guard?

YES/NO

- □ □ Have you had a serious injury to your mouth or head?
- □ □ Do you have earaches, headaches, neck pain?
- □ □ Do you drink bottled water or filtered water?
- □ □ Is your water supply fluoridated?
- □ □ Has fear or an upsetting dental experience kept you from seeking dental care?

Indicate YES to treatment that you experienced by marking on (√) in the boxes below.

□ TMJ/ Bite Splint Therapy □ Denture/ Partial □ Root Canal
□ Periodontal (gum) treatment □ Orthodontics (braces) □ Crown
□ Fillings □ Implant

MEDICAL INFORMATION

Allergies: Please indicate NO/ YES to any previous reactions to items below. To all **YES** responses, **SPECIFY TYPE OF REACTION.**

YES/NO

- □ □ Local anesthetics _____
- □ □ Penicillin _____
- □ □ Other antibiotics _____
- □ □ Sulfa Drugs _____

YES/NO

- □ □ Codeine Drugs
- □ □ Latex (rubber) _____
- □ □Aspirin _____
- □ □ Metals _____

YES/NO

- □ □ Acrylic
- □ □ Barbiturates, sedatives or sleeping pills _____
- □ □ Iodine_____
- □ □ Other _____

Has any physician or previous dentist recommended that you take antibiotics prior to your dental treatment? YES/NO
If YES, please list: Physician/ Dentist name: _____ Phone Number: _____

Please indicate YES/NO to any diseases/problems listed in the columns below.

YES/NO

- □ □ An artificial (prosthetic) heart valve?
- □ □ A damaged valve in a transplanted heart?
- □ □ A congenital heart disease (CHD)?
- □ □ An unrepaired, cyanotic CHD?
- □ □ A repaired (completely) in the past 6 months?
- □ □ A repaired CHD with residual defects?

YES/NO

- □ □ Have you had infected endocarditis (heart infection)?
- □ □ Have you had a total knee/hip joint replacement?
  If YES, when was it placed? Date: _____
  If YES, have you had any complications? _____

(Please complete other side)

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

Date			
Last Name	First		M.I.
Prefers to be called by			
Address			
City	State		Zip
Home Phone No.		Fax	
Cell		Email	
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security No.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

Date			
Last Name	First		M.I.
Address			
City	State		Zip
Home Phone No.			
Birthdate	Age	Male	Female
School			Grade
Social Security No.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

Dental Insurance			
Primary Carrier			
Insurance Company			
Group No.			
Employer Name			
Insured's Name			
Date of Birth		Relationship to Patient	
Insured's I.D. No.			
Insured's Social Security No.			
Secondary Carrier			
Insurance Company			
Group No.			
Employer Name			
Insured's Name			
Date of Birth		Relationship to Patient	
Insured's I.D. No.			
Insured's Social Security No.			

Account Information		
Person Financially Responsible for Account		
Name		
Relationship to Patient	Social Security No.	
Address		
City	State	Zip
Phone No.		
You		
Name		
Occupation		
Employer's Name		
Address	City	
Phone No.	Fax No.	
Your Spouse		
Name		
Occupation		
Employer's Name		
Address	City	
Phone No.	Fax No.	

Getting to know you		
Is another member of your family or relative a patient at our office: Name:	Relationship:	
You were referred to us by		
Your former address		
City	State	Zip
Person to contact for emergency		
Phone number		
Address		
City	State	Zip
Closest relative not living with you		
Phone number		
Address		
City	State	Zip

Please turn over and sign

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the even payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Witness _____

Parent/ Responsible Party's Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I have received, read and understand your *Notice of Privacy Practice*. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information be used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

****

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below: