Northridge Dental

1401 Superior St Suite 5
Lincoln NE 68521
402-477-1177

Date_____

Patient Information

First Name:_____M.I.:_____Last Name:_____Date of Birth:_____

☐ Male ☐ Female Social Security #:_____Email:_____

Street Address:_____City:_____State:_____Zip:_____

Primary Phone_____Home/Cell Secondary Phone:_____Home/Cell

Employer:_____

Emergency Contact:_____Phone:_____Relationship:_____

Spouse/Guardian:_____Social Security #:_____Date of Birth:_____

How did you hear about us? (Please circle) Walk-in Yellow Pages Internet Other (please specify)_____

Were you referred by a current patient?_____

Insurance Policy Holder Information

Name:_____ Social Security #:_____Date of Birth:_____

Street:_____ City:_____State:_____Zip:_____

Phone:_____ Employer:_____Relationship:_____

Primary Dental Insurance Company

Insurance Company:_____ Group #:_____ Member ID #:_____

Secondary Dental Insurance Company

Insurance Company:_____Group #:_____Member ID #:_____

Policy Holder:_____Soc. Sec. #:_____Date of Birth:_____

Employer:_____Relationship:_____

Assignment of Insurance Benefits

I hereby give authorization to release any information including diagnosis and records of any treatment rendered to process my dental insurance claims, and request that payment of benefits be made directly to Northridge Dental. I understand I am financially responsible for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

X_____

Signature of patient or parent/guardian (if patient is a minor) Date

Financial Policy and Arrangements

As a courtesy to our patients, our office will submit insurance claims for the patient-responsible party, however, we require that any deductible and/or co-insurances amounts be paid at the time of service. We offer the following methods or payment: cash, check, or credit card. If you are unable to pay your portion at the time of service, financial arrangements are available. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance prior to services being rendered.

> **Finance charges-** If the entire balance due within 25 days of the first monthly billing date is not paid, then a finance charge of 1.5% will be assessed each month unless a payment plan is arranged or the account is paid in full. Failure to keep the account current with regard to your payment arrangements will then be considered for collection or legal action. At that time, we will be unable to provide additional dental services.

X_____

Signature of patient or parent/guardian (if patient is a minor) Date

Acknowledgement of Receipt and Review of Privacy Policies

I have read and understand the Notice of Privacy Policies. I further understand that if I am unable or choose not to sign this document, a staff member will sign their name and date to verify the Notice of Privacy Policies were reviewed by me, and if I desire a copy of the Notice of Privacy Policies, or my signed copy of the Acknowledgment of Receipt and Review of the Notice of Privacy Policies, I may be given such copy upon request.

X_____

Signature of patient or parent/guardian(if patient is a minor) Date

Financial Authorization

Please indicate the manner in which you wish to handle your account:

____I have no dental insurance. I will pay cash, check, or credit card on the day of the appointment.

____I have dental insurance and will pay my estimated portion of the total.

X_____

Signature of patient or parent/guardian (if patient is a minor) Date

Attention: Please give 24 hour notice is you are unable to keep your appointment. If you fail to come to your appointment twice, we will no longer be able to appoint you at this office.

"NO-SHOW POLICY" INCLUDES A FEE OF $50.00 FOR ANY "NO-SHOW" OF A SCHEDULED APPOINTMENT

Signature_____

Dental/Medical History

Dental History

When was your last dental check up?_____Last dental x-rays?_____

Do you wear dentures or partials? Yes/No Do your gums bleed when your brush or floss? Yes/No

Are your teeth sensitive to Hot/Cold/Sweet/Sour/Pressure How many times per week do you floss?_____

Have your had problems with any of the following?

Bad Breath	Difficult extractions	Sores/Lumps in mouth	Loose teeth or broken fillings
Periodontal Disease	Food collection between teeth	Grinding teeth	Clicking or popping jaw

Do you feel you have any dental problems at this time?_____

Medical History

Have you ever had or do you currently have… (please check yes or no for each)

	Yes	No	Notes		Yes	No	Notes
Arthitis/Rheumatism				Rheumatic fever			
Damaged heart valve				Diabetes			
Mitral valve prolapse				Epilepsy			
Heart murmur				Fainting			
High blood pressure				Headaches			
Low blood pressure				HIV/AIDS			
Chest Pain/angina				Back Problems			
Heart Attacks (when?)				Tuberculosis			
Irregular heartbeat				Shortness of breath			
Cardiac pacemaker				Cancer/which type?			
Heart surgery (when?)				Chemotherapy			
Asthma				Radiation treatment			
Congestive heart failure				Artificial joints			
Hepatitis				Sinus trouble			
Liver disease				Jaw pain			
Stroke (when?)				Blood disease			

Do you have a prosthetic joint/implant? Yes No If so, describe:_____

Have you had a heart valve replacement or vascular graft? Yes No Describe:_____

Has your doctor/previous dentist recommended you take a pre-med antibiotic before dental treatment? Yes No

Have there been any recent changes in your general health? Yes No

Have you had any recent illness or been hospitalized?_____

History Continued

Women, circle if you are: Pregnant Nursing Using birth control

Do you smoke? Yes No Do you use chewing tobacco? Yes No

Do you have a history of drug abuse? Yes No

Do you have any other disease, condition, or problem not listed above that we should know about?

Medications

List any medications you are currently taking

Are you taking blood thinners? Yes No

(Coumadin, Plavix, Aspirin, Vitamin E, Ginkgo Biloba, Xarelto, Pradaxa, Eliquis)

Allergies

Are you allergic to, or had a reaction to	Yes	No	Notes
Local anesthetic (numbing medicine)			
Penicillin			
Other antibiotics			
Sulfa Drugs			
Aspirin			
Codeine			
Acrylic			
Latex			
Metal			

List all other known allergies (do not include food/seasonal allergies)

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Legal Guardian:_____ Date:_____