NORTHERN HEIGHTS DENTAL

WELCOME

Name: _____ Date of Birth: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

(please check one)

Sex : ☐ M ☐ F

Age: _____

(please check one)

☐ Married ☐ Single ☐ Divorced ☐ Partenered

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone: _____

In case of emergency who should be notified? _____ Phone: _____

Primary Dental Insurance

Group #: _____ Subscriber #: _____ Soc.Sec.#/I.D.#: _____

Insurance Address: _____ Insurance Phone: _____

Person Responsible for Account: _____

Relation to Patient: _____ Birth date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Additional Dental Insurance

Is patient covered by additional insurance: (please check one) ☐ Yes ☐ No

Subscriber Name: _____ Birth date: _____ Relation to Patient: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____

Group #: _____ Subscriber #: _____ Soc.Sec.#/ I.D.#: _____

Insurance Address: _____ Insurance Phone: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to JRW Smiles all insurance benefits, if any, otherwise payable to me for services rendered, I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company or Companies, and their agents for the purpose of obtaining payment for services, determining insurance benefits or the benefits payable for related services.I authorize the use or disclosure, as needed, of health information in order to support healthcare operations, third party administrators, or to provide me with information about treatment alternatives and other health related benefits and services that may be of interest.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date:

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date:

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: ☐ M ☐ F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( )
Include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

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Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (check one) ☐ VERY / ☐ SOMEWHAT / ☐ NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____

NORTHERN HEIGHTS DENTAL

Financial Policy

Thank you for choosing Northern Heights Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Northern Heights Dental requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received and any merchant fees, if applicable.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2] Northern Heights Dental will only bill up to two Insurance carriers. Necessary documentation will be provided to you if you choose to bill additional Insurance carriers.

A fee of $75 will be charged to the credit card kept on file for patients who miss or cancel an appointment without 24-hour notice. The above fee MUST be paid in full before any treatment is provided. The credit card authorization must be updated as needed.

Northern Heights Dental charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees **in full**. The credit card authorization kept on your file might be used for this purpose. Any unpaid benefits paid directly from your insurance carrier to us after 60 days of date of service will be refunded to you or maintained as a credit balance in your account.

NORTHERN HEIGHTS DENTAL

Authorization for credit card use

Northern Heights Dental

1100 N San Francisco St Ste D
Flagstaff, AZ 86001
(phone) 928-774-5050 (fax) 928-774-1339

PLEASE COMPLETE THIS AUTHORIZATION All information will remain confidential

Name: _____ Phone: _____

Address: _____ Email: _____

(A copy of your receipt will be emailed to the address provided.)

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____

(last 3 digits located on the back of the credit card)

I authorize JRW Smiles LLC to charge the credit card provided herein. The amount may include any deposit required prior to treatment performed or any remaining balance after primary insurance payment. I also authorize JRW Smiles LLC to charge any balance 90-Days past due on my account, including any applicable appointment fees, finance or service charges to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder - Please Sign and Date

Signature: _____ Date: _____

Print Name: _____

NORTHERN HEIGHTS DENTAL

Records Release/ Request

Authorization for use or disclosure of Dental/Health Information

I, _____ request the release of dental records.

From:_____

_____

_____

_____ (email address for provider)

Name of Patient:_____ Date of Birth:_____

Name of Patient:_____ Date of Birth:_____

Name of Patient:_____ Date of Birth:_____

Name of Patient:_____ Date of Birth:_____

Name of Patient:_____ Date of Birth:_____

Records being requested:

☐ Radiographs
☐ Treatment Notes
☐ Other/Comments:_____

You may revoke this Authorization at any time; however this must be submitted in writing. Revocation will not pertain to information already received or disclosed based on this Authorization during the time frame which the Authorization is effective.

I have reviewed and understand this Authorization. I understand that any information used or disclosed may be re-disclosed by the recipient. If such re-disclosure occurs, the information will no longer be protected under federal law.

_____ _____
Signature Date

(Office only)
ID verified by: _____

Date Rec'd/Sent: _____

1100 N San Francisco St Ste D Flagstaff, AZ 86001
Office: 928-774-5050 Fax: 928-774-1339
northernheightsdental@gmail.com

NORTHERN
HEIGHTS DENTAL

HIPAA Privacy Authorization Form

Northern Heights Dental will not release information about you or your healthcare to anyone, including family members, unless you have given us permission by filling out this form.

Patient Name: _____

Contact Name: _____ Phone #: (___) _____

Address: _____

○ Spouse ○ Family (describe) _____ ○ Friend ○ Emergency Contact

Contact Name: _____ Phone #: (___) _____

Address: _____

○ Spouse ○ Family (describe) _____ ○ Friend ○ Emergency Contact

Contact Name: _____ Phone #: (___) _____

Address: _____

○ Spouse ○ Family (describe) _____ ○ Friend ○ Emergency Contact

1. I hereby authorize Northern Heights Dental to use and disclose my personal health information to the individuals identified on this form.
2. I understand that the individuals identified on this form will be treated by Northern Heights Dental as individuals involved directly in my care and as such Northern Heights Dental will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
3. I understand that I have a right to request and receive a Notice of Privacy Practices from Northern Heights Dental.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Northern Heights dental will not be affected if I refuse to sign this authorization.

Patient signature _____ Date/Time _____