Northern Smiles
DENTISTRY & ORTHODONTICS

Patient Registration

Mrs. Ms. Mr. Dr.

_____
Date

_____
First Name | Middle Initial | Last Name

_____
Preferred Name

_____
Mailing Address | City | State | Zip Code

_____
E-Mail Address

_____
Home Phone | Cell Phone | Work Phone

_____
Social Security Number | Birth Date | Marital Status

_____
Emergency Contact Name | Emergency Contacts Phone Number

_____
Person Responsible for Account | Relationship to Patient | Phone Number of Responsible Person

_____
Social Security Number of Person Responsible For Account | Date of Birth of Person Responsible for Account

_____
Whom may we thank for the Referral?

_____
Name of Medical Physician | Address of Your Medical Physician

_____
Phone Number of Medical Physician | Date of Your Last Medical Physical Examination

_____
Preferred Pharmacy Name | Pharmacy Phone Number

The above information on this form has been accurately answered and is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my or the patient's health. I understand that it is my responsibility to inform Northern Smiles Dentistry and Orthodontics and the rendering Dentist of the dental office of any changes in my or the patient's medical status.

Patient/Guardian signature:_____**Date**_____

Northern Smiles
DENTISTRY & ORTHODONTICS

Financial Policy

Medical Insurance

Subscriber Name: _____ Subscriber Date Of Birth: _____

Subscriber Id Number: _____ Relationship To Patient: _____

Insurance Company Name: _____ Group Number:_____

Insurance Company Phone Number: _____ Name Of Subscriber Employer: _____

Primary Dental Insurance

Subscriber Name: _____ Subscriber Date Of Birth: _____

Subscriber Id Number: _____ Relationship To Patient: _____

Insurance Company Name: _____ Group Number:_____

Insurance Company Phone Number: _____ Name Of Subscriber Employer: _____

Secondary Dental Insurance

Subscriber Name: _____ Subscriber Date Of Birth: _____

Subscriber Id Number: _____ Relationship To Patient: _____

Insurance Company Name: _____ Group Number:_____

Insurance Company Phone Number: _____ Name Of Subscriber Employer: _____

Financial policy

Thank you for choosing Northern Smiles Dentistry & Orthodontics to serve your dental needs. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, and all major credit cards. Outside financing is available upon request and approval. Please ask, if you would like more information about financing options.

Do You Have Insurance? Northern Smiles Dentistry & Orthodontics may or may not be contracted with your insurance company. As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Any insurance reimbursement is limited to the information your insurance company is willing to share prior to treatment. Because your insurance reimbursement is based on a contract between you, your employer, and the insurance company, Northern Smiles Dentistry & Orthodontics is only able to advocate on your behalf. Under no circumstances will any insurance company guarantee payment prior to treatment. While your insurance company is concerned with limitation and policy issues in relation to the premiums paid, Northern Smiles Dentistry & Orthodontics primary concern is for your health. Northern Smiles Dentistry & Orthodontics is committed to maximizing your return from the insurance company and providing you with the highest levels of service and clinical care.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

I understand that any fees incurred will be my responsibility and I will keep my account current. Any remaining balance over 90 days will accrue service charges. Please ask us about any specific questions or concerns you might have in this regard.

A cancellation fee of $50.00 - $100 may be assessed to your account for missed appointments or rescheduling your appointed time without a 48-business hour notification. Leaving a message does not meet these requirements. If there are unusual circumstances surrounding the need to change a scheduled appointment, please speak directly with a team member.

Your signature below acknowledges an understanding that you will be responsible for any additional costs that will not be covered by your insurance plan. The fees in this estimate will be honored for the next 60 days unless you are otherwise notified. I understand that responsibility for payment for Dental Services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that any finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient/Guardian signature:_____ **Date**_____

Northern Smiles
DENTISTRY & ORTHODONTICS

Medical History

Patient Name_____ **Birth Date** _____**Date**_____

Check all of the following that you may have had in the past or that currently apply to you:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial/Orthopedic Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disease
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Dental Implants
- ☐ Diabetes: A1C _____
- ☐ Drug Addiction
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Epilepsy Or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness Spells
- ☐ Frequent Headaches
- ☐ Gastric Bypass surgery
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack_____
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives Or Rash
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble/Infections
- ☐ Sleep Apnea-CPAP?_____
- ☐ Sores or Growths in mouth
- ☐ Stroke_____
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors Or Growths
- ☐ Ulcers
- ☐ Other_____

Are you allergic or have you reacted adversely to any of the following medications?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin/Amoxicillin
- ☐ Percodan
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Valium

☐ Other _____

Have you ever taken any the following medications? Provide Start and Stop date

- ☐ Actonel _____
- ☐ Alentronate _____
- ☐ Aredia _____
- ☐ Boniva _____
- ☐ Fosamax _____
- ☐ Reclast _____
- ☐ Risedronate _____
- ☐ Zometa _____
- ☐ Prolina/Denosumab_____
- ☐ Herbal Supplements_____
- ☐ Ibuprofen_____
- ☐ NSAIDs _____

Are you currently taking any medications? If yes please list:_____

_____

Do you need Antibiotics prior to receiving Dental Care? If so, what type/dosage? _____

Do you take Coumadin or Plavix or any other blood thinner? If yes, do you know your typical INR?_____

How would you describe your present health (circle one): Excellent / Good / Fair / Poor / Don't know

When was your last visit with your Primary Care Physician? _____

Are you currently under a physician's care? If yes please list for what:_____

Has there been any change in your general health in the past year? If yes, please explain: _____

_____

Have you ever had any serious illness, hospitalization or condition not listed above in the last 5 years? If yes please describe:

_____

What is your current weight? _____What is your height ?_____

Is there a history of diabetes in your family? If yes, who:_____

Are you a past or present smoker/vapor? Yes/ No If yes, how many Cigarettes/Cigars/mg per day_____Do you Chew Tobacco? Yes/ No

Do you have any history of substance abuse or do you currently use recreational drugs? Yes / No

For Women, Check All That Are Appropriate:

☐ I Am Pregnant/Trying to get pregnant ☐ I Am Nursing ☐ I Am Taking Birth Control Pills

The above information on this form has been accurately answered and is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my or the patient's health. I understand that it is my responsibility to inform Northern Smiles Dentistry and Orthodontics and the rendering Dentist of the dental office of any changes in my or the patient's medical status.

Patient/Guardian signature:_____ **Date**_____

Blood Pressure/Heart Rate_____

Doctor's Signature:_____ Date_____

Northern Smiles
DENTISTRY & ORTHODONTICS

Dental History

Patient Name_____ **Birth Date** _____**Date**_____

Date of Last Dental Cleaning?_____ What is the frequency of cleanings?_____

How Many Times a Day do you Brush Your Teeth?_____ How Many Times a Day do you Floss?_____

What Type of Tooth Brush do you Use? _____

Do you use a water Pik? Yes / No

Please Rate Your Current Dental Health: Excellent Good Fair Poor

How Would you Rate Your Smile: Excellent Good Fair Poor

Are Your Teeth Sensitive to: Heat Cold Sweets Pressure Brushing Flossing

Yes	No	(If Yes, Please Explain)
☐	☐	Do you experience dry mouth?
☐	☐	Do your Gums Bleed?
☐	☐	Would you prefer to be Sedated for Dental Treatment?
☐	☐	Are you concerned with Tooth Loss or Wearing Dentures?
☐	☐	Have you ever had Orthodontic Treatment (Braces)?
☐	☐	Have you ever had trouble getting Numb and/or had Reactions to Local Anesthetic?
☐	☐	Have you noticed any Loose and/or Shifting Teeth?
☐	☐	Have you noticed any Bad Tastes or Bad Breath?
☐	☐	Have any of your family members had Advanced Gum Disease, Wear Partials or Dentures?
☐	☐	Do you have any Clicking, Popping, and/or Discomfort in the Jaw?
☐	☐	Do you Clench and/or Grind Your Teeth?
☐	☐	Do you wear a Nightguard or Appliance? _____
☐	☐	Are you experiencing any discomfort? _____
☐	☐	Have you ever had Periodontal (Gum) treatment? _____
☐	☐	Have you ever had Deep Cleaning (Scaling with Local Anesthesia)?_____
☐	☐	Have you had problems associated with previous Dental Treatment? _____

The above information on this form has been accurately answered and is true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my or the patient's health. I understand that it is my responsibility to inform Northern Smiles Dentistry and Orthodontics and the rendering Dentist of the dental office of any changes in my or the patient's medical status.

Patient/Guardian signature:_____**Date**_____

Northern Smiles
DENTISTRY & ORTHODONTICS

Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's **Notice of Privacy Practices**.

Please Print Your Name

Signature Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____	_____
Please Print Name	Relationship	Phone number
_____	_____	_____
Please Print Name	Relationship	Phone number
_____	_____	_____
Please Print Name	Relationship	Phone number

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):

_____

_____

Northern Smiles
DENTISTRY & ORTHODONTICS

GUM DISEASE RISK ASSESSMENT

Patient Name_____ **Birth Date** _____**Date**_____

In our practice, we strive to provide our patients with optimal oral health. We are focused on preventing or limiting periodontal (gum) disease, and dedicated to identifying and treating disease early, when the pain and costs associated with treatment are much less.

According to the National Center for Biotechnology Information, "***Significant associations between periodontal disease and cardiovascular disease, diabetes mellitus, preterm low birth weight, and osteoporosis have been discovered, bridging the once-wide gap between medicine and dentistry.***"

Please take a few minutes to answer the questions below so that we can assess your individual risk for gum disease and tailor our treatment recommendations to your specific needs.

Risk Factors For Gum Disease	**Response (Circle "Y" for "Yes" and "N" for "No")**	**Score**	**Facts**
Do you floss daily?	Y=0; N=2		Per American Dental Association (ADA): 20% never floss; 40% 1 x per day
Are you age 35 or older?	Y=2/N=0		Per Centers for Disease Control (CDC): 47% age 30+ have periodontal disease; 70% of Americans age 65+ have periodontal disease
Do you have a family history of premature adult tooth loss and/or gum disease?	Y=2/N=0		Per CDC: 34% of adults age 40+ have tooth loss
Do you have a history of heart disease and/or are you taking medication for hypertension?	Y=2/N=0		Per CDC: Hypertension: 29% of population; Heart Disease: 11% overall, 48% women;46% men
Are you taking medication for diabetes?	Y=2/N=0		Per CDC: 30% of Americans have diabetes or pre-diabetes; age 45-64:17% have diabetes; age 65+: 25%
Have you ever been a tobacco user (including smokeless tobacco) and/or smoker of any kind (including marijuana/vape)?	Y=2/N=0		Per CDC: Tobacco use and smoking of any kind doubles the risk of periodontal disease
Is there redness on toothbrush or in the sink when you rinse after brushing?	Y=1/N=0		
Do you have persistent bad breath (noticed by you, your partner/friend/colleague)?	Y=1/N=0		
Have you noticed a movement/shifting of teeth (gaps developing, tooth/teeth mobility)?	Y=1/N=0		
Do you occasionally experience discomfort/pain when eating/chewing?	Y=1/N=0		
Total Score			

LOW TO MODERATE RISK: **Total score of 0-3**
MODERATE TO HIGH RISK: **Total score of 4-9**
HIGH RISK: **Total score of 10 or higher**