

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 _____

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** _____

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:

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

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

- | | | | |
|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Percodan | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Other _____ | | | |

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Actonel _____ | <input type="checkbox"/> Boniva _____ | <input type="checkbox"/> Risedronate _____ |
| <input type="checkbox"/> Alendronate _____ | <input type="checkbox"/> Fosamax _____ | <input type="checkbox"/> Zometa _____ |
| <input type="checkbox"/> Aredia _____ | <input type="checkbox"/> Reclast _____ | <input type="checkbox"/> Prolina/Denosumab _____ |
| <input type="checkbox"/> Herbal Supplements _____ | <input type="checkbox"/> Ibuprofen _____ | <input type="checkbox"/> 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

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Patient/Guardian signature: _____ Date _____

Blood Pressure/Heart Rate _____

Doctor's Signature: _____ Date _____

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) |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience dry mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your Gums Bleed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Would you prefer to be Sedated for Dental Treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you concerned with Tooth Loss or Wearing Dentures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Orthodontic Treatment (Braces)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had trouble getting Numb and/or had Reactions to Local Anesthetic? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any Loose and/or Shifting Teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any Bad Tastes or Bad Breath? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any of your family members had Advanced Gum Disease, Wear Partials or Dentures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any Clicking, Popping, and/or Discomfort in the Jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you Clench and/or Grind Your Teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear a Nightguard or Appliance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you experiencing any discomfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Periodontal (Gum) treatment? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Deep Cleaning (Scaling with Local Anesthesia)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had problems associated with previous Dental Treatment? _____ |

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



**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):

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**



Photography Release/Consent Form

Here at Northern Smiles Dentistry & Orthodontics, we make every effort possible to make our patients feel special. We like to acknowledge how great our patients are by posting relevant awards, newspaper articles, photos from prize winnings/drawings and sharing them on our social media platforms. Please check one of the following boxes and sign below.

- I AGREE** and hereby grant full permission to Northern Smiles Dentistry & Orthodontics, Dr. Troy Stansberry & Team to use my name(s) and photographs in publication. This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or name. I understand that these images will not be used for any commercial use.

Be sure to follow our social media platforms to keep up to date with new events happening!

www.northernsmilesdentistry.com

[@northernsmilesdentistry](https://www.instagram.com/northernsmilesdentistry)

[www.facebook.com](https://www.facebook.com/northernsmilesdentistry) @northernsmilesdentistry

- I DO NOT AGREE** to have my photograph or name for public viewing

Name (printed): _____

Signature: _____

Date: _____

