North Auburn DENTISTRY

2350 Grass Valley Hwy, Auburn, CA 95603
Ph: (530) 823-2423
Fax: (530) 823-5580
www.northauburndentistry.com

Today's Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell (_____) _____

How did you hear about our office? _____ Driver's License Number _____

Employer _____ Bus. Tel. (_____) _____

In case of emergency, please contact _____ (FIRST NAME) _____ (LAST NAME) Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S. # _____ Birth Date _____ Age _____

Tel. (_____) _____ Cell (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic. # _____ Employer _____ Bus. Tel. (_____) _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel. (_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex ❑ M ❑ F

S.S. # _____ Tel. (_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel. (_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex ❑ M ❑ F

S.S. # _____ Tel. (_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying at the time services are rendered. Other arrangements can be made with our office manager depending upon special circumstances. An **estimate** of the charge for any procedure or surgery you may require will be given. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but pleae complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

X _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**

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MEDICAL HISTORY

Please check the boxes of the following problems or conditions that you have or have had in the past:

- ❑ No Known Medical Conditions
- ❑ Aids
- ❑ Allergies (Seasonal)
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Bruise/Bleed Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Diabetes
- ❑ Dizziness
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Heart Conditions
- ❑ Heart Lesions
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Jaw Joint Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervousness/Depression
- ❑ Osteoporosis/Bone Density
- ❑ Pacemaker
- ❑ Phen Fen (1 Month+)
- ❑ Pregnant Currently
- ❑ Radiation (Head/Neck)
- ❑ Respiratory Problem
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Diseases
- ❑ Other _____

_____

_____

Are you sensitive/allergic to any of the following:

- ❑ No Known Allergies
- ❑ Aspirin
- ❑ Codeine
- ❑ Darvon
- ❑ Erythromycin
- ❑ Local Anesthetic
- ❑ Nitrous Oxide
- ❑ Penicillin
- ❑ Percodan
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Valium
- ❑ Other _____

_____

_____

_____

Are you under a physician's care? ❑ **Yes** ❑ **No**

What for: _____

Family Physician: _____ Phone: _____

Patient Name: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature (or Parent/Guardian): _____ Date: _____

Signature of Dentist: _____ Date: _____

MEDICATIONS

Are you taking any mediations? ❑ **Yes** ❑ **No**

What are they?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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DENTAL HISTORY

Are you experiencing or ever experienced any of the following:

	Yes	No
Tooth Sensitivity (Hot, Cold, Sweet)	❑	❑
Where: UR LR UL LL	❑	❑
Headaches, Earaches, Neck Pain	❑	❑
Jaw Joint Pain	❑	❑
Teeth or Fillings Breaking	❑	❑
Grinding or Clenching Teeth	❑	❑
Bleeding, Swollen or Irritated Gums	❑	❑
Loose, Tipped or Shifting Teeth	❑	❑
Bad Breath	❑	❑

If you could change your smile, would you...?

	Yes	No
Make them whiter?	❑	❑
Make them straighter?	❑	❑
Close spaces?	❑	❑
Repair chipped teeth?	❑	❑
Replace missing teeth?	❑	❑
Replace old crowns that don't match?	❑	❑
Replace black metal fillings?	❑	❑
Have a smile makeover?	❑	❑

Do you have or have you had any of the following?

	Yes	No
Dentures	❑	❑
Partial Dentures	❑	❑
Braces	❑	❑
Periodontal (Gum) Treatment	❑	❑

Date of Last Cleaning: _____

Date of Last Oral Cancer Screening: _____

Date of Your Last Complete X-Rays: _____

Name of Last Dentist: _____

Phone & Address of Last Dentist: _____

_____

_____

Why did you leave your previous Dentist? _____

_____

_____

Did you smoke of use chewing tobacco? _____

How Much: _____ How Long? _____

On a Scale from 1 - 10 (10 being the highest):

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
How do you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

What is the most important thing to you about your dental visit today?

_____

What is the most important thing to you about your future smile and dental health?

_____

Print Patient Name: _____

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 dental 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.

Patient Signature (or Parent/Guardian): _____ Date: _____

Doctor Signature: _____ Date: _____

POS Reorder # 1715902

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FINANCIAL POLICY

Thank you for choosing North Auburn Dentistry. 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:

North Auburn Dentistry requires payment at the beginning of your treatment, If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

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]

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

North Auburn Dentistry charges $30 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.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Patient Name (Please Print) Date

[1] Subject to credit approval
[2] However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I have been given the Dental Materials Fact Sheet as required by law dated May 2004.

I give my permission to North Auburn Dentistry to release information regarding my appointments or account information to

_____ .

_____
Date

_____
Print Patient Name

_____
Signature

_____
Relationship to Patient