

Please complete all information that applies to you – Thank you.

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Email Address _____

D.O.B. _____ Age _____ Social Security Number _____

Responsible Party: _____

Address: _____

Phone: () _____

Insurance Information

Dental Insurance Co. _____ Group Number _____

Name of Insured (if other than self) _____

Social Security Number of Insured (if other than self) _____

Address of Insured (if other than self) _____

Employer: _____

Emergency Contact Information

Name of Contact: _____

Phone Number: _____

Relationship to Patient: _____

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

X _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No	
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Head, neck, jaw pain, or aches	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please explain _____
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had trouble from previous dental care?
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	(cold, heat, sweets)			<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____
Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss?			_____
Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush?			

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations Yes No If yes, please describe _____

Have you ever had a blood transfusion Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Due date _____ Nursing? Yes No Taking birth control pills? Yes No

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Any immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head/neck	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with operations or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under the care of a Physician?	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic/sensitive to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Penicillin, Aspirin, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please specify _____		
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	List any medications that you are taking:		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Doctor Signature: _____ Date _____

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All Patients must complete our "Patient Information Form" prior to being seen by the Dental Professional
- Full Payment is due at the time of Service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service.

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parents, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non – emergency treatment will be denied unless charges have been pre-authorized.

Insurance

- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount maybe subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by the staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to. However, if you are paid by the insurance company instead of, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to a NSF fee of \$25.00

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____

Date _____



Non-Discrimination Policy

North American Dental Group and its affiliates comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. North American Dental Group and affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If requested, North American Dental Group and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the Office Manager at the practice location.

If you believe that North American Dental Group and affiliates have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kiena P Nutter- Compliance Coordinator
11 S Mill St
New Castle, PA 16101
724.698.2905
[*nutterk@nadentalgroup.com*](mailto:nutterk@nadentalgroup.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kiena P Nutter, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ADA Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. *You have a right to choose your own dentist and schedule an appointment in a timely manner.*
2. *You have a right to know the education and training of your dentist and the dental care team.*
3. *You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.*
4. *You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.*
5. *You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.*
6. *You have a right to an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.*
7. *You have a right to be informed of continuing health care needs.*
8. *You have a right to know in advance the expected cost of treatment.*
9. *You have a right to accept, defer or decline any part of your treatment recommendations.*
10. *You have a right to reasonable arrangements for dental care and emergency treatment.*
11. *You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.*
12. *You have a right to expect the dental team members to use appropriate infection and sterilization controls.*
13. *You have a right to inquire about the availability of processes to mediate disputes about your treatment.*
14. You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

Patient Responsibilities

1. *You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.*
2. *You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.*
3. *You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.*
4. *You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.*
5. *You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.*
6. *You have the responsibility to keep your scheduled appointments.*
7. *You have the responsibility to be available for treatment upon reasonable notice.*
8. *You have the responsibility to adhere to regular home oral health care recommendations.*
9. *You have the responsibility to assure that your financial obligations for health*

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment.