North Country Dental New Patient Packet - Child

Today's Date: _____

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Sex: M / F / Unspecified

DOB: ____/_____/_____ SSN: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address (if different):_____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Work Phone: (____)_____-_____

Preferred daytime phone number: □ Home □ Cell □ Work

Do you prefer to receive your statements via: □ Email or □ USPS mail? (Please select only ONE.)

Father's Name: _____ DOB: ____/____/_____ SSN: _____ Phone: (___)____-_____

Father's Address: □ Check here if same as above

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address (if different):_____

Mother's Name: _____ DOB: ____/____/_____ SSN: _____ Phone: (___)____-_____

Mother's Address: □ Check here if same as above

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address (if different):_____

FINANCIAL RESPONSIBLE PARTY

□ Parent(s) □ Guardian* □ Other*

***If "Guardian" or "Other" is checked, complete the below information. (Legal documentation required.)**

First Name: _____ M.I.: _____ Last Name: _____ DOB:____/_____/_____

SSN: _____ Relationship to Patient: _____ Phone Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address (if different):_____

DENTAL INSURANCE

We are in network with Northeast Delta Dental*, but we also accept out-of-network insurances.

We do not accept Medicaid in any form.

*If your Delta Dental insurance is PPO ONLY, please be sure to inform us prior to your appointment. Not all our providers are enrolled with Delta Dental as PPO providers. This may affect your coverage, resulting in higher cost to you.

PRIMARY DENTAL INSURANCE

Primary Subscriber:_____

Address:_____

Relation:_____ DOB: ____/____/_____

SSN:_____ Tel. (____)_____-_____

Employer Group:_____

ID#:_____ Group#:_____

Ins. Co. Name:_____

Claims Address:_____

Tel. (___)____ -_____

SECONDARY DENTAL INSURANCE

Primary Subscriber:_____

Address:_____

Relation:_____ DOB: ____/____/_____

SSN:_____ Tel. (____)_____-_____

Employer Group:_____

ID#:_____ Group#:_____

Ins. Co. Name:_____

Claims Address:_____

Tel. (___)____ -_____

HEALTH HISTORY

Chief dental concern: _____

Primary care physician: _____ Phone: (____)_____-_____

Location: _____ Date of last visit: _____

Preferred pharmacy :_____

Have there been any changes in your general health in the past year? □ Yes □ No

Does your physician recommend antibiotic pre-medication for dental procedures? □ Yes** □ No

** If YES, please ask your PCP or surgeon to fill your prescription. The American Dental Association guideline is that premeds are no longer recommended for joint replacements. Your surgeon may recommend otherwise. Your dental provider is not part of this treatment and will not prescribe for it.

Do you have a prosthetic joint? □ Yes □ No

Do you have a history of prosthetic joint infection(s)? □ Yes □ No

Do you have a history of endocarditis? □ Yes □ No

□ Check here only if you are NOT taking any medications. Otherwise, please list below.

Medications (Rx, OTC, vitamins):	**Reason for Taking:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

□ Check here only if you have NO known allergies. Otherwise, please list below.

Allergies (meds, food, etc):

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH HISTORY CONTINUED

Check if you **HAVE** or **HAVE HAD** any of the following:

High/low blood pressure (circle one)	◯	Thyroid condition	◯
Cardiovascular condition	◯	Diabetes/high/low blood sugar	◯
High cholesterol	◯	Kidney disorder*	◯
Cardiac pacemaker/defibrillator	◯	* If **yes**, are you on dialysis? ○ Yes ○ No	
Heart valve replacement or vascular graft	◯	Arthritis/joint disease	◯
Heart surgery	◯	Osteoporosis/osteopenia	◯
Heart attack(s)	◯	Osteonecrosis	◯
Stroke	◯	Use of bisphosphonates (e.g. Actonel, Fosamax)	◯
Pulmonary (lung) issues	◯	Chronic pain/pain management	◯
Difficulty breathing/shortness of breath	◯	Acid reflux/stomach/esophageal ulcers	◯
Asthma	◯	Sexually transmitted disease(s)	◯
Sinus issues	◯	HIV/AIDS	◯
Snoring/sleep apnea*	◯	Compromised immune system	◯
* If **yes**, do you use a CPAP/snore device? ○ Yes ○ No		Slow healing from wounds	◯
Tuberculosis	◯	Recurrent growths/sore areas in/around mouth	◯
Tobacco/vaping use?	◯	Tumor(s) or cyst(s)	◯
Blood disorder such as anemia	◯	Cancer	◯
Bleed/bruise easily	◯	History of radiation or chemotherapy	◯
Liver disease/jaundice/hepatitis	◯	History of alcohol abuse	◯
Fainting spells	◯	History of drug abuse	◯
Epilepsy/convulsions	◯	Pain or clicking of jaws when eating	◯
Chronic fatigue	◯	Headaches or migraines*	◯
Anxiety/depression +	◯	* If **yes**, frequency: _____x week _____x month	
History of mental illness +	◯	Use of night time mouth guard	◯

+ If **yes**, please describe: _____

_____

_____

_____

_____

WOMEN

Possibility of pregnancy? □ Yes □ No If YES, due date:_____/_____/_____ Are you nursing? □ Yes □ No

Are you using a form of birth control*? □ Yes □ No

**Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control.*

CONSENT FOR TREATMENT

Please read and initial the items below and SIGN at the bottom of the form.

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Parent/Guardian Initials:_____

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. If it becomes necessary to alter my treatment plan during the course of treatment, I will be informed.

Parent/Guardian Initials:_____

DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Parent/Guardian Initials:_____

CONSENT TO BILL

I give permission to the dental office to bill my dental insurance provider for the treatment provided (if applicable).

Parent/Guardian Initials:_____

HIPAA ACKNOWLEDGEMENT

The full Notice of Privacy Practices is posted in the waiting room. A printed version is available upon request.

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

Parent/Guardian Initials:_____

RESCHEDULE AND CANCELLATION POLICY

We respectfully request at least two business days' (48 hours) notice to cancel or reschedule an appointment. A minimum of 1 business day's notice (24 hours) is required. Same-day cancellations (cancelled short notice) and no-call no-show appointments (failed) are charged a minimum fee of $40.00. Missed appointments over one hour long may be charged a higher fee. Our providers' time is valuable, just like yours, and lost appointment time cannot be made up. Three failed or cancelled short notice appointments in a 12-month period will be considered for dismissal from the practice.

Parent/Guardian Initials:_____

Parent/Guardian Signature: _____ **Date**:____/_____/_____

FINANCIAL POLICY

PAYMENT FOR SERVICES:

Payment is due and expected at the time of treatment. The following methods of payment are accepted: cash, check, debit card, credit card, HSA/FSA card, and CareCredit. There is a 3% surcharge on credit card transactions. This does not apply to debit cards, HSA/FSA cards, or CareCredit cards.

INSURED PATIENTS:

We understand the value of insurance benefits and will assist you in obtaining your maximum dental benefits. We will submit claims to your dental insurance company on your behalf. Your insurance may not cover the cost of your treatment in full. Any charges not paid by insurance are the responsibility of the patient (or the patient's financial guarantor).

Your estimated coinsurance payment is due at the time treatment is rendered, and any additional balance remaining after your insurance has processed your claim is billable to you. Estimates are a courtesy based on the information provided to us by you

FINANCIAL POLICY CONTINUED

and your insurance company. We are not part of your insurance contract, and we cannot guarantee what your insurance will pay. It is the responsibility of the patient to ensure coverage and eligibility. An insurance pre-treatment estimate of benefits can be submitted at your request.

Claims aged 45+ days remaining unpaid by insurance may be closed and billed to the patient.

COLLECTIONS POLICY:

Balances 60+ days old may be transferred to our collections agency. A $30 fee is assessed to offset the cost to the office. Patients transferred to collections may be dismissed from the practice for nonpayment of account.

I understand and agree to the above financial policies.

Parent/Guardian Signature: _____ **Date**:____/_____/_____