

Welcome to Northwest Dental!

Date _____

Patient Info

Name _____ Birthdate _____ Gender _____

Status (circle one) Minor Single Married SSN # _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Spouse _____ Spouse Phone _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about us? _____

Primary dental Insurance: Please present your card(s) when completed so we may verify information.

Primary Subscriber Name _____ Birthdate _____ SS# _____

Employer _____ Identification # _____ Group Number _____

Ins. Company _____ Phone _____

Secondary dental Insurance: Please present your card(s) when completed so we may verify information.

Secondary Subscriber Name _____ Birthdate _____ SS# _____

Employer _____ Identification # _____ Group Number _____

Ins. Company _____ Phone _____

Patient Dental Health History

Name of previous/referring dentist or office _____ Phone _____

Date of last exam _____ Date of last X-rays _____

Have you had dentures/partial dentures before? Yes No

If yes, how old are they? _____ Who made them? _____

Patient Medical History

Patient Name _____ Date _____

Primary Care Doctor _____ Doctor's Phone _____ Last Exam _____

Do you see your doctor regularly/for regular checkups? Yes No
Have you been hospitalized for any surgical operation/serious illness within the last 5 years? Yes No

Please List Hospitalizations (include approximate dates):

Medications: Please list below or provide us with a list.

Do you use tobacco products? Yes No Type: Cigarettes Chew
Do you use controlled substances? Yes No
Do you take a blood thinner? Yes No
Do you take any Osteoporosis Medications? Yes No
Do you require antibiotic premedication prior to dental treatment? Yes No
Preferred Pharmacy: _____

Are you allergic to or have you had an adverse reaction to any of the following?

Local Anesthetics (Novocain) Sedatives Barbiturates
Antibiotics (i.e. Penicillin) Metals
Aspirin Latex/Rubber
Other: _____

Have you ever had any of the following (circle all that apply)?

Anemia	Arthritis	Artificial Joints
Asthma	Cancer	Stroke
Diabetes	Dizziness/Fainting	Tuberculosis
Excessive Bleeding	Epilepsy	HIV/AIDS
Head Injuries	Heart Disease	Pacemaker
Heart Murmur	Hepatitis	Respiratory Problems
High Blood Pressure	Liver Disease	Sinus Problems
Tumors	Mental Disorders	Rheumatism
Nervous Disorders	Radiation Treatments	Rheumatic Fever

Other: _____

Women Only:

Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

Cancellation/missed appointment policy:

In order to keep our level of service, our office requires 2 business days notice (within office hours) to change or cancel an appointment. All appointments late, cancelled or missed without 2 business days notice will be subject to a \$75 per hour fee not billable to insurance. Messages left must be within business hours or it will not be considered sufficient notice. Our business hours are Monday–Thursday from 8:00 a.m. to 5:00 p.m. Multiple missed appointments may result in same day appointments only or dismissal from practice. We require that all appointments be confirmed in order to reserve your appointment time, you can call our office and speak with the front desk to confirm or leave a message within business hours. Any appointments left unconfirmed may be double booked. As a note, our Medicaid patients will not be charged the \$75 no-show/late cancel fee and instead will be put on a same day appointment basis after two missed appointments.

Understanding your insurance:

Your insurance benefits are an agreement between you and your insurance company. We are happy to bill your carrier as a courtesy; however, you are ultimately responsible for any account balance if your insurance does not cover their portion as expected. It is your responsibility to know and understand your insurance benefits as well as notify our office of any changes to your coverage. We will do our best to estimate portions due and help you to understand your coverage based on the information available to us. These estimates are NOT a guarantee of coverage or payment on behalf of your insurance company. Estimates are valid for 90 days.

Written financial policy:

Thank you for choosing Northwest Dental. Our primary mission is to deliver the best and most comprehensive dental and denture care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Northwest Dental requires full payment at the time of service. We offer financing through CareCredit and can assist you with the application process, but we do not allow in-office monthly payments. If you have insurance, we require your estimated portion to be paid in full at the time of service. We will do our best to calculate what your portion will be based on the information provided by your carrier. Your insurance benefits are an agreement between you and your insurance company. We are happy to bill your carrier as a courtesy; however, you are ultimately responsible to pay the account in the event that they do not cover their portion. Balances over 90 days (including insurance portion) will incur a 1% per month finance charge (12% per annum). Should you need financial assistance, please ask us to provide information regarding CareCredit to assist in your needs. We require a payment equal to at least half of the total charge for dentures, partials crowns, and bridges due at the initial impression appointment. The balance is to be paid at the delivery date. Temporary partials must be paid in full at the time of impression. Northwest Dental charges \$25 for returned checks. If you have any questions, please do not hesitate to ask. .

Payment options:

We accept cash, check, Visa, MasterCard, American Express, Discover Card or Care Credit.

Available discounts:

For our patients with no dental insurance, we offer 5% off.

We offer \$25.00 off per denture on a new (first with our office) set of dentures!

"I agree to and understand Northwest Dental's office and financial policies. I understand that it is my responsibility to know my insurance benefits and keep Northwest Dental updated on changes to my coverage."

Patient Name

Patient, parent, or guardian/representative Signature

Date