NEW PATIENT INFORMATION FORM

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICK NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ SS#: ___ - ___ - ____

E-MAIL ADDRESS: _____

DOB: ___ / ___ / ____ MARITAL STATUS: _____ GENDER: M / F

EMPLOYER NAME AND ADDRESS: _____

REFERRING DR: _____ REFERRING PT: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ___ - ___ - ____ DOB: ___ / ___ / ____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ___ - ___ - ____ DOB: ___ / ___ / ____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

Signature: _____

Please write any additional insurance information on the back of this form - Thank You!

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP | Heart Rate:

Height:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fen-Phen
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS

Y	N	Conditions
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Latex Sensitivity
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Milk Allergy
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pine Nut Allergy
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Snore

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Tumors
☐	☐	Ulcers
☐	☐	Venereal Disease

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

TRUE NORTH DENTAL GROUP

OFFICE FINANCIAL POLICY

Payment is due at the time services are rendered. For your convenience we accept cash, personal checks, money orders, Visa, Mastercard, Discover, American Express and Care Credit. Payment plans and financial arrangements can be entered into for comprehensive dental treatment prior to commencing care. A fee of $30.00 will be added to your account for any checks returned by your bank.

Insurance benefits are determined by your employer, not your dentist. Insurance is not a guarantee of payment; it will not cover all your costs. Your insurance policy is a contract between you and your insurance company. Payment to True North Dental Group is ultimately your responsibility. We will do our best to maximize all the benefits that you are legally entitled to. As a courtesy we will be glad to file your claim for you. Please provide us with your dental insurance information and required employer.

Unpaid Balances may result in an account being submitted to a collection agency. Unpaid balances will be referred to CBM Services, Inc. and will include a 25% fee on the balance that will be the patient's responsibility

Continuity and consistency of care are key to maintaining proper dental health. Maintaining a relationship with our patients is our first priority. Individuals who have not been seen in the practice within 5 years will be considered a new patient to the office. Your appointment is reserved exclusively for you; therefore courtesy of advance notice when you are unable to keep an appointment is appreciated and required. We reserve the right to charge and collect fees for appointments that are cancelled or broken without 24 hour notice. Providing advance notice allows other patients who may have been waiting for an appointment the opportunity to be seen. We reserve the right to dismiss any patient from the practice who misses or cancels, without 24 hour notice, three or more consecutive appointments. Furthermore, patients who consistently change appointments with or without notice may be subject to dismissal. Cancellations with less than 24 hours notice are considered missed appointments. Appointment changes must be made directly through the office, a message may be left on the machine when the office is not open.

I have been given the opportunity to ask questions regarding this policy. I have read and understand the financial policy.

Signature:_____ Date:_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs. I consent to photography, study models and x-rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____