NORTH CANYON
DENTISTRY

New Patient Information

Name:_____ Date:_____

Referred by:_____ DOB:_____ Genre: M F SS#_____

Marital status:_____ Email:_____

Address:_____ ZIP_____

Cell phone:_____ Home Phone:_____

Responsible party if minor:_____

Relationship to the patient:_____

Primary Holder of Insurance

Relationship to policy holder:_____

Name:_____ DOB:_____

Address:_____ ZIP_____

Cell phone:_____ Home Phone:_____

Insurance company:_____ ID#_____

Secondary Holder of Insurance

Relationship to policy holder:_____

Name:_____ DOB:_____

Address:_____ ZIP_____

Cell phone:_____ Home Phone:_____

Insurance company:_____ ID#_____

Authorization to assign benefits and release medical information

For services rendered, I hereby assign payment from my insurance company to North Canyon Dentistry. I shall be financially responsible to pay for any non-covered charges, unpaid balances, deductibles or co-insurances.

_____

Patient / parent

17215 N 72nc Dr Suite A100 Glendale, AZ, 85308. phone 623-582-8384

NORTH CANYON DENTISTRY

Medical History

Patient name: _____ nickname_____ Date: _____

Physician's name: _____ Most recent physical exam:_____

Purpose: _____

Estimate your current health status: excellent___ good ___ fair ___ poor ___

Do you have or have ever had:

1. Hospitalization for illness or injury — Yes No
2. An allergic reaction to: — Yes No
   - aspirin, ibuprofen, acetaminophen, codeine — Yes No
   - penicillin — Yes No
   - erythromycin — Yes No
   - tetracycline — Yes No
   - sulfa — Yes No
   - local anesthetic — Yes No
   - fluoride — Yes No
   - metals (nickel, gold, silver) — Yes No
   - Latex — Yes No
   - Other_____ — Yes No
3. Heart problems, or cardiac stent in the last 6 months — Yes No
4. History of endocarditis — Yes No
5. Artificial heart valve, repaired heart defect (PFO) — Yes No
6. Pacemaker or defibrillator — Yes No
7. Artificial prosthesis, WHEN?_____ — Yes No
8. Low blood pressure — Yes No
9. High blood pressure — Yes No
10. A stroke — Yes No
11. Anemia or other blood disorder — Yes No
12. Digestive disorders (i.e. gastric reflux) — Yes No
13. Emphysema, sarcoidosis — Yes No
14. Tuberculosis — Yes No
15. Asthma — Yes No
16. Breathing or sleep problems (i.e. snoring) — Yes No
17. kidney disease — Yes No
18. Liver disease — Yes No
19. Diabetes — Yes No
20. Thyroid disease — Yes No
21. Hormone deficiency — Yes No
22. High cholesterol — Yes No
23. Anxiety — Yes No
24. Depression — Yes No
25. ADHD — Yes No
26. Osteoporosis/osteopenia — Yes No
27. Arthritis — Yes No
28. Head or neck injury — Yes No
29. Epilepsy, convulsions (seizures) — Yes No
30. Radiotherapy / Chemotherapy — Yes No
31. Tumor, abnormal growth — Yes No
32. HIV / AIDS — Yes No
33. Viral infections and cold sores — Yes No
34. Any lumps or swelling in the mouth — Yes No
35. Hives, skin rash, hay fever — Yes No
36. STI / STD — Yes No
37. Hepatitis — Yes No
38. Rheumatic or scarlet fever — Yes No

ARE YOU:

43. User of marijuana — Yes No
44. User of alcohol — Yes No
45. A smoker or Vaper — Yes No
46. User of smokeless tobacco — Yes No
47. Take blood thinners — Yes No
48. Take bisphosphonates (alendronate) — Yes No

_____ Patient Signature

_____ Doctor's Signature

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NORTH CANYON
DENTISTRY

DENTAL HISTORY

Name: _____ Nickname:_____Age: _____
Referred by _____I see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. other
How would you rate the condition of your mouth? Excellent /Good / Fair / Poor
Previous Dentist? _____ How long have you been a patient? ____ Months /Years
Date of most recent dental exam: _____ Most recent x-rays: _____Most recent treatment: _____
WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 to 10	Y	N
2. Have you had an unfavorable dental experience?	Y	N
3. Have you ever had complications from past dental treatment?	Y	N
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	Y	N
5. Did you ever have braces, orthodontic treatment or have your bite adjusted?	Y	N
6. Have you had any teeth removed?	Y	N
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth the you would like to change?	Y	N
8. Have you ever whitened (bleached) your teeth?	Y	N
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	Y	N
10 Have you been disappointed with the appearance of previous dental work?	Y	N
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping?	Y	N
12. Do you, would you have any problems chewing gum, bagels, baguettes, protein bars or other?	Y	N
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	Y	N
14. Are your teeth crowding or developing spaces?	Y	N
15. Do you have more than one bite and squeeze to make your teeth it together?	Y	N
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	Y	N
17. Do you clench your teeth in the daytime or make them sore?	Y	N
18. Do you have any problems with sleep or wake up with an awareness of your teeth?	Y	N
19. Do you wear or have you ever worn a bite appliance?	Y	N
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years?	Y	N
21. Do you frequently get food caught between any teeth?	Y	N
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing?	Y	N
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	Y	N
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	Y	N
25. Do you have grooves or notches on your teeth near the gum line?	Y	N
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filing?	Y	N
GUM AND BONE		
27. Have you experienced a burning sensation in your mouth?	Y	N
28. Do your gums bleed or are they painful when brushing or flossing?	Y	N
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	Y	N
30. Have you ever noticed an unpleasant taste or odor in your mouth?	Y	N
31. Is there anyone with a history of periodontal disease in your family?	Y	N
32. Have you ever experienced gum recession?	Y	N
33. Have you ever had any teeth loose on their own (no injury), or do you have difficulty eating?	Y	N

Date:_____

_____ _____
Patient's Signature Doctor's Signature

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NORTH CANYON
DENTISTRY

Current Medications List

Name:_____ Date:_____

Blood Pressure: _____ Pulse:_____ Oximeter:_____

Medication / Supplements	Condition for medication	Frequency	Dose

Pharmacy information: _____

Patient signature

_____

Doctor's signature

_____

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NORTH CANYON
DENTISTRY

Patient Acknowledgement of North Canyon Dentistry HIPAA Notice

Patient's Name:_____

I understand that the patient's health information is private and confidential. I understand that North Canyon Dentistry works hard to protect my/the patient's privacy and to preserve the confidentiality of my/the patient's health information.

I understand the North Canyon Dentistry may use or disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be other uses and disclosures of this information unless I permit it.

North Canyon Dentistry has a detailed document called the "Notice of Privacy Practices". It contains more detailed information about how they may use and disclose patient health information and I acknowledge that I have been given the opportunity to review a full copy of this "Notice" and that I may request a copy for my records.

North Canyon Dentistry may update the "Notice of Privacy Practices". If I ask, North Canyon Dentistry will provide me with the most current "Notice of Privacy Practices".

My signature below indicates that I have had an opportunity to review and receive a copy of North Canyon Dentistry's "Notice of Privacy Practices".

_____ _____

patient or (parent, legal guardian) Date

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NORTH CANYON
DENTISTRY

Financial Policy

Thank you for choosing North Canyon Dentistry (NCD) as your dental care provider. Our purpose is to provide the finest dental care in a relaxed and caring environment. NCD's financial policy is documented to ensure transparency in the areas of finance, payments and insurance. It is important that our communication is simple and straight forward as we partner together with our patients. Anyone within our leadership team will be happy to answer any questions you may have.

Please Initial Each Item Below

1. _____Payment Methods: We accept Cash, Checks, Visa, MasterCard, Discover and Care Credit. There will be a charge of $50 for returned checks to cover bank charges and special handling.
2. _____ Required Documents: Items we require include updated copies of your health history, insurance card, and a photo for Security purposes. Some insurance carriers require your social security number for insurance billing and processing.
3. _____Patient Payment: Co-pay, deductibles and coinsurance are all due and payable at the time of your appointment and/or Procedure. All payments are estimated based on the information we have received from your insurance carrier. Any unpaid balances will be the responsibility of the patient and will be due immediately upon billing from NCD.NCD is bound to the final decisions made by your in-network insurance company.
4. _____Claim Submission & Assignment of Benefits: NCD agrees to files insurance claims on behalf of the patient for up to two insurance carriers. The patient agrees to release those funds in full to NCD. NCD will assist in filing appeals, however, your coverage is a contract between insured and the insurance company.
5. _____NCD fee schedule: NCD goes to great lengths to insure the fees charged in the office are both reasonable and follow all applicable guidelines. We are unable to negotiate reduced fees (co pays. deductibles, etc) with your insurance carrier.
6. _____Contact Information: It is the patient's responsibility to notify NCD of any changes to insurance coverage, Insurance card, Residence, mailing address, email, phone number and email address. We use a confirmation and contact software allowing for great communication if we have the proper contact information.
7. _____Timely Payment of Outstanding Funds: NCD will receive and EOB (explanation of Benefits) from the patient's Insurance payor, which notifies NCD of the final payment decision and outstanding balances due from the patient. Insurance companies are legally allowed 30 pays for processing a claim and returning payment. Should payment be left unpaid at 60 days, the outstanding funds will be deemed patient responsibility. Patient will be notified via statement and patient agrees to pay those funds in full upon receipt.
8. _____Collection Activity: NCD is willing to discuss payment arrangements. If the final payment is not made witnin 60 days of statement date, delinquent accounts are released to U.S. Collections West. Inc. at which time additional fees will be added to the outstanding balance. This includes a contract fee of 50% of the final bill and up to 20% APR billed monthly, along the any legal fees.
9. _____No-show fee: We do require 48-hour cancellation notice and we reserve the right to assess a $50 per hour fee for all missed appointments. Should missed appointments become habitual, NCD reserves the right to discontinue the provider/patient relationship.
10. _____Privacy Practices: I have had the opportunity to review the privacy practices of North Canyon Dentistry.

Acknowledgements: I have read and understand the above NCD Financial Policy. I have been given the opportunity to ask any questions and have agreed and initialed above. I further understand that refusal to sign or comply with the above policies will result in being released from the practice (using guidelines as applicable by law).

Print Patient Name _____

Patient or Responsible Party Signature _____

Date _____

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