NorthStar DENTAL

PATIENT REGISTRATION

Thank you for choosing NorthStar Dental as your dental care home.
So we can best serve you, please take a few minutes to complete this form.

Patient Information

Patient Name _____ Preferred Name _____

Home Phone _____ Cell _____ Email _____

Address _____ City _____ State _____ Zip_____

Sex: ☐M ☐F DOB_____ SS# _____-_____-_____

Employer _____ Work Ph. _____

Emergency Contact: _____ Emergency Contact Phone#_____

How did you hear about our office? _____ Referral's name_____

Last Dental Visit _____ Physician's Name _____ Last Visit to Physician_____

Billing Information

Insurance ☐ Self-pay ☐ Flex Plan / HSA ☐ CARE-CREDIT ☐ Other _____

Primary Dental Insurance _____ Insurance Phone # _____

Group # _____ Member # _____ SS# _____-_____-_____

Subscriber _____ DOB_____ Relationship to patient _____

Secondary Dental Insurance _____ Phone # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage as noted above, and assign directly to NorthStar Dental all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submissions. NorthStar Dental practice may use and disclose my personal information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits, or the benefits payable for related services.

Patient/Guardian Signature: _____ **Date:** _____

NorthStar Dental Health History

Dental Health History (Circle Yes or No)
Please complete to the best of your knowledge.

Do you want complete dental care? Y N
Are you apprehensive about dental treatment? Y N
Are you dissatisfied with the appearance of your teeth? Y N
Have you had problems with previous dental treatment? Y N
Do you gag easily? Y N
Do you have difficulty swallowing? Y N
Do you avoid brushing any part of your mouth because of pain? Y N
Do your gums bleed when you brush or floss? Y N
Does your mouth feel dry often? Y N
Have you noticed slow-healing sores in your mouth? Y N
Are your teeth sensitive Y N
- Hot foods or liquid? Y N
- Cold foods or liquid? Y N
- Sweets? Y N
- Biting? Y N

Does your jaw make noise that bothers you or others? Y N
Do you clench or grind your teeth frequently? Y N
Do you have any jaw soreness, or headaches upon awakening in the morning? Y N
Do you chew on only one side of your mouth? Y N
Do your gums feel swollen or tender? Y N
Does food get stuck in one area? Y N
Do you experience ringing in the ears? Y N

Medical Health History
(Do you have, or have you had, any of the following?)

AIDS/HIV Y N
Anemia Y N
Arthritis, Rheumatoid Y N
Artificial Heart Valves Y N
Artificial Joints Y N
Location_____
Joint Reinfections Y N

Medical Health History (Cont.)
Asthma Y N
Back Problems Y N
Bleeding Problems/Easy Bruising Y N
Blood Disease Y N
Cancer, Type_____ Y N
Chemical/Alcohol Dependency Y N
Chemotherapy Y N
Circulatory Problems Y N
Congenital Heart Problems Y N
Cortisone Treatments Y N
Cough, persistent or bloody Y N
Depression/Anxiety Y N
Diabetes, Type I or II Y N
Emphysema Y N
Epilepsy / Siezures Y N
Fainting/Dizziness Y N
Glaucoma Y N
Head injury Y N
Heartburn Y N
Heart Problems Y N
Hepatitis, type_____ Y N
Herpes or other STD Y N
Heart Murmur Y N
High blood pressure Y N
Jaundice Y N
Kidney Disease Y N
Liver Disease Y N
Low Blood Pressure Y N
Lupus Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Psychiatric Care Y N
Radiation Treatment Y N
Respiratory Disease Y N
Rheumatic Fever Y N
Scarlet Fever Y N
Scleroderma Y N
Shortness of Breath Y N
Sinus Trouble Y N
Skin Rash Y N
Special Diet Y N
Stroke (When)_____ Y N
Swollen Feet or Ankle Y N
Swollen Neck Glands Y N
Sjogren's Y N
Thyroid Problems Y N
Tonsillitis Y N
Tuberculosis Y N
Tumor or growth on head/neck Y N
Ulcer Y N
Weight loss, unexplained Y N

Airway Health
Do you feel excessively tired throughout the day? Y N
Do you wish you slept better and had more energy? Y N
Have you ever been told you occasionally snore? Y N
Have you or a loved one been prescribed a C-PAP? Y N
Have you had a sleep study? Y N

Women:
Are you pregnant? Y N
Expected delivery date _____
Taking contraceptives or other hormones? Y N

Medications Allergies
Aspirin Y N
Codeine Y N
Ibuprofen Y N
Latex Y N
Local anesthetics Y N
Metals Y N
Penicillin/Amoxicillin Y N
Sulfa Y N
Tylenol Y N
Other_____

Medications (list all currently taking)

_____

_____

_____

_____

_____

_____

Other Condition or Disease not listed:

_____

_____

_____

Consent: I hereby agree to allow Dr. Ronngren and associates to perform any necessary, agreed upon dental services. I also allow all them to delegate to the auxiliaries of their choice as needed to accomplish my treatment. I understand that there is an inherent risk with any dental procedure, including dental anesthesia. I hereby allow them to take any necessary x-rays, study models or photographs as needed for my dental care. I understand that the entire fee is my responsibility and that NorthStar Dental will submit to my dental insurance as a courtesy. I agree to be responsible for any collection fees necessary to pursue a past debt.

Patient Signature: _____ Date: _____ Provider Signature: _____ Date: _____

OFFICE POLICIES

Thank you for choosing NorthStar Dental and trusting us as your dental health care provider. Our goal is to provide patients optimal dental care. We want you to ask questions throughout our relationship, and be involved in treatment decisions.

APPOINTMENTS

Appointments are carefully scheduled to best serve our patients. As a courtesy we provide a variety of appointment reminders including text messages, email, and voice messages left with roommates/family members or answering machines containing appointment dates and times. Our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel last minute. If you must reschedule we require 24-hour notice for any cancelled appointment.

FINANCIAL AGREEMENT

Payment for our services are due at the time they are rendered. Patients who have dental insurance are expected to pay their estimated co-pay and deductible at the time of service, as we additionally process your insurance claims for you. Payments may be made using Cash, Check, Visa, Mastercard, Discover, and American Express. We also offer CARECREDIT which is an outside financing option available for healthcare expenses on approval of credit.

Having dental insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. It is your responsibility to provide and/or update us with your dental insurance card, and if applicable all required employer and personal information. As a courtesy, we will file your claim for you. **Insurance companies may send reimbursement for dental care directly to the policy holder, in which circumstances it is the patient/policy holder's responsibility to reimburse NorthStar Dental. If your insurance has not paid NorthStar Dental within 60-days of services rendered, patient and/or policy holder will be responsible for full payment and/or monthly interest of 3.6% (APR36%) to our office.** Please remember insurance policies are a contract between you and your insurance company. The insurance company is more responsive to the policy holder. After 60-days the patient is responsible to pursue payment from the insurance company, and all current documentation will be provided upon request in order to assist your inquiries. **If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.**

NOTICE OF PRIVACY PRACTICES / ACKNOWLEDGEMENT

We keep a record of the health care services we provide for you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us. Our **Notice of Private Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Added Disclosure – I authorize the following person(s) to have access to all health and financial information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your signature below indicates that you have read, understand and agree to the terms and conditions of the Office Policy and acknowledge receipt of Notice of Privacy Practices.

_____

Print Patient Name

_____ _____

Patient Signature / Parent or Guardian (if patient is a minor) **Date**