General Information

NORTHVIEW DENTAL

Thank you for choosing our practice. Please fill out this form as completely as you can.
If you have any questions we'll be glad to help. (Please print)

Patient Information

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. Other _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Home Number _____

Employer _____ Work Number _____

Are You [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated

DOB _____

Is Patient a Full Time Student? [ ] No [ ] Yes Name of School _____

Spouse's Name _____

Spouse Occupation _____ Work Number _____

Your Preferences

Do you prefer appointment reminders by [ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at [ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you? _____

How do you wish to be addressed by our staff? _____

Responsible Party (if different than patient)

Name _____

Address _____

City _____ State _____ Zip _____

Home Number _____

Work Number _____

DOB _____

SSN# _____

Relationship _____

CEREC 3D

Northview Dental is one of the most advanced practices in the US. We use CEREC technology to produce ceramic restorations in a single visit

Our practice uses CEREC 3D technology to make ceramic crowns, onlays, and veneers in a single appointment.

Cone Beam CT

3D xrays are taken to identify potential issues before they become painful emergencies

Insurance information

NORTHVIEW DENTAL

Medical Insurance

Subscriber's Name _____ Relationship to Patient _____

DOB _____ Subscriber's SSN _____

Subscriber's Employer _____ Employers Name _____

Insurance Company _____ Policy # _____

Group # _____

Dental Insurance

Insured Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB _____ SSN# _____ Employer _____

Insurance Company _____ Group # _____ Eff. Date _____

Do You Have Additional Dental Insurance?

[ ] Yes [ ] No If yes, please complete the following

Insured Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB _____ SSN# _____ Employer _____

Insurance Company _____ Group # _____ Eff. Date _____

Notice of Privacy Practices

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable), my other dental or medical providers and family or non-family members listed above:

Signature of Patient _____ Date _____

This practice can bill many procedures to your medical insurance carrier which limits your financial responsibility.

General Consent

NORTHVIEW DENTAL

General Consent To Diagnose and Treat

The undersigned herby authorizes Northview Dental of Indianapolis to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Northview Dental of Indianapolis to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Northview Dental of Indianapolis choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Northview Dental of Indianapolis. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

Financial Consent

I understand that responsibility for the payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance. I consent and acknowledge that I am responsible for all fees necessary to collect my account. I authorize Northview Dental of Indianapolis and their staff to verify insurance coverage, if any, to submit claims, and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (Adult)

Name of Patient _____ Date _____

Signature of Patient/Guardian _____

Northview Dental of Indianapolis has permission to contact me via [ ] Text [ ] Email [ ] Both

Emergency Contact

Name _____ Phone _____

Relationship to Patient _____

Medical History

NORTHVIEW DENTAL

Why do we ask these questions?

Date Created _____

Although dental professionals primarily treat the area in and around your mouth, past or current health conditions, medications you are taking, or symptoms you are experiencing could have important interrelationship with the dentistry you receive.

Patient Name _____ DOB _____

Height _____ Weight _____

General Single Questions

		If Yes
Are you currently being treated by a physician for a specific health concern?	[ ] Yes [ ] No	
Are you having any tooth or jaw pain?	[ ] Yes [ ] No	
Do you snore at night? If yes, do you use a CPAP or other treatment?	[ ] Yes [ ] No	
Do you take, or have you taken, Phen-Fen or Redux?	[ ] Yes [ ] No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?	[ ] Yes [ ] No	
Are you on a special diet?	[ ] Yes [ ] No	
Do you use tobacco?	[ ] Yes [ ] No	
Are you taking any medications, pills, or drugs?	[ ] Yes [ ] No	

_____

_____

Women: Are You...

- ☐ Pregnant/Trying to get Pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

Other Allergies?	[ ] Yes [ ] No	
Do you use a controlled substance?	[ ] Yes [ ] No	

Medical History

NORTHVIEW DENTAL

Do you have, or have you had, any of the following?

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Breathing Problems
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Dry Mouth
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Hepatitis B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Hives or Rash
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Blood Transfusion
- [ ] Frequent Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Trouble/Disease
- [ ] GERD/Acid Reflux
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Renal Dialysis
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] Artifical Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Osteoporosis
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Psychiatric Care
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Excessive Thirst
- [ ] Fainting Spells/Dizziness
- [ ] Frequent Cough
- [ ] Stomach/Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsilitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Tumors or Growths
- [ ] Mitral Valve Prolapse
- [ ] High Cholesterol

Have you ever had any serious illness not listed [ ] Yes [ ] No _____

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the detal office of any changes in medical status.

Signature _____ Date _____

Photo Consent

NORTHVIEW DENTAL

Consent of Photographic Use

I hereby grant Northview Dental permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration.

I understand and agree that these materials will become the property of Northview Dental and will not be returned.

I hereby authorize Northview Dental to edit, alter, copy exhibit, publish or distribute this photo for the purposes of publicizing Northview Dental's business or for any other lawful purpose including education or teaching purposes. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Northview Dental from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

Signature _____ Date _____

Printed Name _____ Date _____

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____ named above, and do hereby give my consent for the terms noted above.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Date _____