REGISTRATION

Please complete all information below.

Name: _____ Date of Birth: _____

Preferred name if different from above: _____

Cell Phone: _____ Home Phone: _____ Social Security No._____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Please Check Appropriate Box: □ Child □ Single □ Married □ Divorced □ Widowed □ Separated

Present Employer: _____ Position: _____ Work Phone: _____

Spouse's Full Name: _____

Spouse's Employer: _____ Position: _____ Work Phone: _____

If for child or teen under 18, please list:

Father's Full name: _____

Father's Employer: _____ Work Phone: _____

Mother's Full Name: _____

Mother's Employer: _____ Work Phone: _____

Children in family (name and age):

_____ _____

All accounts are due 30 days from the date of service. Balances not clear within 60 days are subject to an annual rate of 8%. Please feel free to discuss your account with our business office at any time.

Name of person responsible for account: _____

Name of any person allowed to receive information about your dental care (ex. Parent, Spouse, Guardian): **Age 18+**

_____

Name and phone number of two people whom we may contact in care of an emergency:

_____ _____

DENTAL INSURANCE INFORMATION:
Please list ALL dental insurance carriers (especially if you have dual coverage and Medical Assistance)

1. _____ ☐ Self ☐ Spouse ☐ Parent
2. _____ ☐ Self ☐ Spouse ☐ Parent

Whom may we thank for this referral? _____

☐ Online ☐ Walk in ☐ Other Source

I hereby authorize the staff of this office to perform those dental procedures necessary to accomplish this agree-to-treatment. (Provided the benefits, alternatives, discomforts and risks will be explained to me and that my special consent will be obtained for procedures with potentially serious complications.)

Signature: (Parent or Guardian if a minor) _____ Date: _____

Account #_____

NorthwayDental associates

Patient Health History

PATIENT'S NAME: _____

Last First MI Date of Birth

_____

Prior Dentist/Clinic Name **(New Patients only)** City/State Last Dental Exam

_____

Physician Name Medical Clinic Name Last Physical Exam

Allergies- Select all that apply:

[ ] Aspirin Allergy [ ] Codeine Allergy [ ] Erythromycin Allergy [ ] Hay Fever

[ ] Latex Allergy [ ] Local Anesthetic Allergy [ ] Metal Allergy [ ] Penicillin Allergy

[ ] Sulfa Allergy [ ] Other Allergy: _____

MEDICATIONS – Please list all medications you are currently taking:

_____

_____

_____

_____

_____

_____

Have you had any serious illnesses or surgeries? (Describe) _____

_____

Are you currently Pregnant or Nursing? ( ) Yes ( ) No

Are you Using Birth Control Pills? ( ) Yes ( ) No

Do you smoke or use tobacco products? ( ) Yes ( ) No

Do you habitually use controlled substances? ( ) Yes ( ) No

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DO YOU HAVE OR HAVE YOU EVER HAD: (check all that apply)

( ) Cardiovascular Disease/ Angina

( ) Heart Pacemaker/Defibrillator

( ) Heart Murmur

( ) Artificial (Prosthetic) Heart Valve

( ) Congenital Heart Disease (CHD)

( ) Previous Infective Endocarditis

( ) Asthma

( ) Blood Disease

( ) Anticoagulants

( ) High Blood Pressure

( ) Low Blood Pressure

( ) Stroke

( ) Gastrointestinal Disease

( ) Kidney Disease

( ) Liver Disease

( ) Thyroid Problems

( ) Diabetes

( ) Arthritis/Rheumatoid Arthritis

( ) Autoimmune Disease

( ) Artificial Joints

( ) Osteoporosis/Osteopenia

( ) Cancer

( ) Tumors

( ) Chemotherapy/Radiation Treatment

( ) Epilepsy

( ) Hepatitis

( ) Tuberculosis

( ) Glaucoma

( ) Herpes

( ) Sexually Transmitted Disease

( ) HIV or AIDS

( ) Mental Health Disorder

( ) Other conditions not noted_____

_____

_____

_____

COMMENTS:

_____

_____

_____

By signing this form, I certify that the above information is true and correct to the best of my knowledge.

_____

Patient or Legal Guardian Signature Date

_____

Provider Signature Date

NORTHWAY DENTAL ASSOCIATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protective health information, and of other important matters about your protected health information. A copy of your Notice accompanies this Consent. WE encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notices, at any time.

Right to revoke: You will have the right to revoke this Consent at any time by giving us a written notice of our revocation submitted to Northway Dental Associates. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my written consent to you to use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Medical Information Release Form

(HIPAA Release Form)

Full Name: _____ Date of Birth: ___/_____/_____

Release of Information

I authorize the release of information including diagnosis records, examination rendered to me and claim information. This information may be released to the person(s) below:

[ ] Spouse: _____

[ ] Child (ren): _____

[ ] Parent(s): _____

[ ] Other: _____

[ ] I choose **not** to have my information to be released to anyone.

This Release of Information will remain in effect until terminated by patient in writing.

Contact Information for Patient

Please contact me by:

[ ] Cell Phone: _____

[ ] Home Phone: _____

[ ] Work Phone: _____

If you are unable to reach me:

[ ] You may leave a detailed message at the above number

[ ] You can text a detailed message to my cell phone

[ ] Do **not** leave a detailed message, I will return your call

Signed: _____ Date: _____/_____/_____

NORTHWAY DENTAL ASSOCIATES
1500 Northway Drive, St. Cloud, MN 56303
320-253-7700
Fax 320-253-9271
www.northway-dental.com

CREDIT AGREEMENT

Credit Policy. I understand that all charges are due and payable within 30 days following the date they are billed unless I make other arrangements with your business office. I understand that my insurance policy is a contract between me and my insurance company. As a service to me, you will file my primary insurance form at no charge. If the insurance company does not pay my claim within 30 days after it is mailed, you ask that I pay the balance of my account and contact my insurance company regarding my settlement. You will assist me in processing my claim. However, I understand that my account is always billed to me and that I am personally responsible for payment of my account. If for some reason I am having a personal financial crisis, I will contact your credit department to discuss a payment schedule. If I do not pay my account within 30 days after it is mailed, you will treat it as a loan under this agreement.

Finance Charges. You will charge a FINANCE CHARGE for each day that the loan is not repaid. There is a grace period of 60 days during which I may pay the loan without incurring a FINANCE CHARGE. The present periodic rate that you use to figure the FINANCE CHARGE is an Annual Percentage Rate of 8%.

Figuring the FINANCE CHARGE. You figure the finance charge to my account by applying the periodic rate to the amount I owe at the end of each billing cycle (deducting payments and credits made during the billing cycle).

Minimum Payment Requirements. If I do not pay my account in full within 30 days following the date it is billed, I will contact you to arrange a payment schedule.

In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse, and to my minor children. I/We agree to pay all charges not covered by insurance.

Statements. Each month you will mail to me a statement showing services, payments, and credits made to my account during the previous month and the date my payment is due. The statement will be considered correct unless I notify you by using the procedure explained on the reverse side of this agreement.

Default. You can terminate my account without any advance notice to me and require me to pay you the entire outstanding balance in one payment if: (a) I do not meet the repayment terms; (b) I do not comply with this agreement; (c) I am bankrupt or insolvent; or (d) I die.

Termination. Either of us may terminate this agreement by giving 30 days' written notice to the other at any time, but I will still have to pay back my unpaid balance.

Your Rights if I am in Default. You may accept late payments, partial payments, or any payments marked as being payment in full or as being in settlement of any dispute without losing any of your rights under the law. I may have to pay any reasonable attorneys' fees and other costs of collection unless prohibited by law.

In this agreement, the words "I", "me", and "my" mean each and all of those who sign below. The words "you" and "your" mean Northway Dental Associates.

I agree to all of the above. I understand that the reverse side contains additional terms and important information regarding my rights to dispute billing errors.

Date: _____

Patient, parent, or guardian

_____

(borrower)

2500SR806

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. (Northway Dental will be assigned payment benefits and will then apply that amount to your account.)

SIGNATURE

DATE