North Star Dentistry

Care You Deserve, Experience You Love, Smile You Desire!

Patient Information

Full Name: _____Sex: M / F

Nickname: _____ Child/Single/Married/Divorced/Separated

Date of Birth: _____/_____/_____SSN:_____-_____-_____

Address: _____

City: _____ _____State:_____ Zip Code: _____

Phone: Home____-_____-_____ Cell_____-_____-_____ Work_____-_____-_____

Email Address: _____

Driver's License #:_____State:_____

Employment Information

Current Employer:_____ How Long:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Employer Phone: _____-_____-_____ Fax:_____-_____-_____

Spouse Information

Name: _____

Date of Birth: _____SSN:_____-_____-_____

Employer: _____ How long: _____

Employer Address: _____

Phone: Home____-_____-_____ Cell_____-_____-_____ Work_____-_____-_____

Email Address: _____

Responsible party Self: Yes / No

If not self, Name: _____

Relationship to patient: _____Date of Birth: ____/_____/_____

SSN: _____-_____-_____ Driver's License #:_____

Address: _____

_____

City:_____ State:_____ Zip Code:_____

Phone: Home _____ Cell:_____ Work _____

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Insurance Information

Name of the insured:_____

Insured's Employer:_____

Insurance Name: _____

Insurance Ph #:_____-_____-_____ Dental Coverage: Yes / No

Group # (policy #):_____ Subscriber ID #:_____

Emergency Contact

Name of the person not living with you:_____

Relationship:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home____-_____-_____ Cell_____-_____-_____ Work_____-_____-_____

Appointment Reminders

How should we contact you for appointment reminders (check **all** that apply)

- ☐ Phone - __Home, __Work, __Cell, __Other-specify _____
- ☐ Email (if different than above) _____
- ☐ Text message (SMS) (if different than above) _____

How Did You Hear About Us (Check **all** that apply)

- ☐ Internet: Site: www._____Phrase:_____
- ☐ Insurance Company: _____
- ☐ Referred by Patient: _____
- ☐ Referred by health provider: _____
- ☐ Other - Please specify: _____

Authorization And Release

1. I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous.
2. I authorize **North Star Dentistry** to take X-rays, models, photos and/or other diagnostic aids necessary for a thorough oral diagnosis of myself and/or my minor dependents.
3. I also authorize **North Star Dentistry** to release any such information to third party payers and/or healthcare practitioners for the purpose of rendering treatment, payment activities and healthcare operations.
4. I understand and acknowledge that **North Star Dentistry** may use my photographs and images in marketing campaign for educational purposes to potential patients.
5. I understand that my dental insurance carrier may pay less than the actual bill of services, I agree to be responsible for payment of all services rendered on my behalf or my dependents.
6. I authorize and request my insurance company to pay directly to **North Star Dentistry,** the insurance benefits payable to me.

Signature of patient/parent of minor : _____Date: _____

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Patient Health Information

Reason for this visit: _____

Have you ever had any of the following :

___Angina	___Excessive Bleeding	___Liver Disorders	___Stroke
___Allergies	___Fainting	___Mental Disorders	___Tuberculosis
___Artificial Valves	___Nervous Disorders	___Tumors	___Bruise easily
___Anemia	___Growths	___Pacemaker	___Ulcers
___Arthritis	___Hay Fever	___Pregnancy	___Venereal Disease
___Artificial Joints	___Head Injuries	___HIV Positive	___Blood Transfusion
___Asthma	___Heart Disease	___Radiation Treatment	___Sickle Cell Disease
___Blood Disease	___Heart Murmur	___Respiratory Problems	___Cortisone medicine
___Cancer(Chemo)	___Hepatitis	___Rheumatic Fever	___Pain in Jaw Joints
___Diabetes	___High Blood Pressure	___Rheumatism	___STD
___Dizziness	___Jaundice	___Sinus Problems	___AIDS
___Epilepsy	___Kidney Disease	___Stomach Problem	___Other, specify

Do you have any drug allergies? Yes / No
If yes, please specify _____

Have you had any skin reactions to jewelry or know of any allergy to metal or any other substance? Yes / No If Yes, Please specify _____

Are you taking any medications/ drugs at this time? Yes / No
If yes, please specify _____

Have you ever had any complications following dental treatment? Yes / No

Have you been admitted to a hospital or needed emergency care during the past 2 years? Yes / No _____

Are you under the care of a physician? Yes / No
Name of Physician: Phone:
Details: _____

For Women: Are you Pregnant? Yes / No If yes, what month? _____

Last dental visit: Month/ year____ /_____
Reason for last visit: _____

Is there anything about your smile(old fillings, broken teeth) that you don't like?
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____ _____

Signature **Date** **Name (Please Print)**

North Star Dentistry

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I, _____, have received a copy of this office's Notice of Privacy Practices.
Address: _____

To the Patient - PLEASE READ THE FOLLOWING 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 protected health information, and of other important matters about your projected health information. A copy of our Notice is available to you - we encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy policies 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 of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our Receptionist at 214-488-3368 or fax your request to 214-446-8957.
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our receptionist. Please understand that revocation of his 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 consent to your use and disclosure of my protected health information to carry out treatment, payment activities and other health care operations.

_____ _____

Signature Date

North Star Dentistry

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Financial Policy

Thank you for choosing us to provide your dental health. We are committed to your successful treatment. The following is a statement of our Financial Policy. Please read carefully and sign prior to any treatment.

_____ Insurance

- We file for the insurance claim on your behalf. Many plans may and do place limits on the coverage for treatments as per terms agreed with your employer. We do not file claims to secondary insurance.
- We do strive to present to you the most accurate estimate or actual charges prior to the treatment. If, for any reason, insurance claims are denied, you are responsible for the charges not paid by the insurance, including, but not limited to, any co-payment, co-insurance and deductible.
- If the insurance company has not paid the amount in full in 45 days, the balance is then your responsibility. We will notify you of any non-payment or delayed payment in writing.
- A pre-authorization may be sent at your request. This does NOT guarantee full payment by your insurance company.

_____ Financing

- We accept cash, checks, debit cards, Visa and Mastercard.
- We also provide financing through Care Credit subject to approval. A minimum amount may be required for qualification.

_____ Minor Patients

- The adult (parent/guardian) accompanying a minor is responsible for full payment. In the event of a divorce/separation, the parent/guardian accompanying the child will be responsible for the payment regardless of agreement between parents or the courts.

_____ Past Due Accounts

- All payments are due at the time of the treatment.
- Any account balance due over 45 days will be assessed a finance charge of 1.25% per month. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency.

_____ Missed Appointment:

- Unless canceled a scheduled appointment atleast **24 hours in advance**, we reserve the right to charge a fee of minimum $25.

_____ Returned Checks:

- There will be a $30 service charge for all returned checks.

_____ Transfer and copies of record

- North Star Dentistry may charge a fee of $25 for each request for transfer of patient records (paper or electronic), including copies of X-rays, photos. Original x-ray, photos, models remain the property of North Star Dentistry.

_____ (initials) I authorize and request my insurance company to pay directly to North Star Dentistry, the insurance benefits otherwise payable to me.

_____ (initials) I have read, understand and agree to the terms of this Financial Policy.

Name (Please Print**):** _____

X_____ **Date:** _____
Authorization by Patient/Responsible Party

Care You Deserve, Experience You Love, Smile You Desire!

North Star Dentistry
2601 S Stemmons Fwy
STE # 160
Lewisville, TX-75067

Patient Name:_____

GENERAL CONSENT FOR DENTAL TREATMENT

As a patient you will at all times have access to current and complete information about your condition and will, unless otherwise specified, receive continuity of treatment, be provided an estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. (Before receiving treatment you should ask the dentist or dental hygienist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done.)

All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result of care. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. Your have the right to consent to or refuse any proposed procedure at any time prior to its performance.

DIAGNOSTIC & PREVENTIVE SERVICES: I understand the need for and consent to all necessary Diagnostic X-Rays, Cleaning of Teeth, Application of Topical Fluoride, & Placement of Sealants for myself or my child whenever deemed appropriate by the dentist. (If there is an estimated out-of-pocket expense to you for any preventive services, we will attain your approval again prior to placement.)

DENTAL ANESTHETICS: I understand the risks as well as the benefits associated with Topical Anesthetics and Local Dental Anesthetic Injections and hereby consent to their use whenever deemed appropriate by the dentist for any dental procedures including but not limited to Fillings, Root Planing & Scaling, Crowns Bridges, Dentures, and Root Canal Therapy for myself or my child.

EMERGENCY CARE: Emergency dental care treatment is intended to provide relief of severe pain and infection for individuals in acute need. You as a patient of record have access to a dental emergency service. There is a charge associated with this service.

DENTAL RECORDS: The dental medical record, radiographs (x-rays), photographs, videos, models and other diagnostic aids relating to your dental treatment are the property of North Star Dentistry.You have the right to inspect such materials and to request a copy of your dental medical records and radiographs. There is at least $25.00 fee for copying these items. You may also requests to have your dental radiographs sent to another health care provider by signing a Release of Information form.

Your signature on this form certifies that you have read and understand the information provided on the form, that you accept the dental care and treatment under the described terms and conditions.

Patient:_____ **Date:**_____
Signature