NovaDental
PARTNERS

Acknowledgment of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment form third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my dental provider's NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such NOTICE OF PRIVACY PRACTICES.

I understand that my dental provider has the right to change the NOTICE OF PRIVACY PRACTICES and that I may contact this office at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date**: _____

Dependent family member also covered by this acknowledgement:_____

Signature X: _____

Relationship to Patient: _____

NovaDental PARTNERS

Financial Policies

YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE INDICATES THAT YOU UNDERSTAND AND AGREE TO OUR FINANCIAL POLICIES.

Full payment is due at the time services are rendered.

FOR PATIENTS WITH INSURANCE:
We do accept assignments of your insurance benefits; however, we do require that your co-payment and deductible be paid in full at the time of your appointment. The balance is your responsibility whether your insurance pays for your treatment or not. In the event that your insurance does not pay as much as we anticipate, you are responsible for the remaining bill. It is imperative that you inform us of any changes in your insurance coverage **PRIOR TO TREATMENT**.

Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company, and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help.

Any claims unpaid within 60 days of the date of service become the patient's responsibility.

- Payment may be made via Cash, Check, Discover, MasterCard or Visa
- A charge of $50 per half hour may be applied to your account for broken appointments, unless a 48-hour notice is given
- There is a $30 +$5 bank fee for all returned checks

I understand the above and agree that if full payment is not made within the 60 day grace period, that I am responsible for the balance. If my account goes to a third party for collection, I understand that I will be responsible for any fees involved in the collection process. This includes but is not limited to court costs and attorney fees in addition to the outstanding balance.

Patient Name: _____ **Date**: _____

Signature X: _____

NovaDental PARTNERS

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your oral health.

1. PATIENT INFORMATION

Date: _____ Email: _____

Patient Name: _____ Occupation: _____

SS #: _____ Patient Employer: _____

Address: _____ School/School Phone #: _____

City: _____ Whom may we thank for referring you?

State: _____ Zip: _____ Direct Mail ◯ Zocdoc ◯ Yelp ◯ Family/Friends ◯

Gender: M_____ F_____ D.O.B.: _____ Insurance ◯ Google ◯ Other: _____

Marital Status: (Circle one that applies to you)

Married Separated Widowed Divorced Single Partnered Minor

Responsible Party - IF SAME AS ABOVE PLEASE SKIP

Full Name: _____ Cell #: _____ Work #: _____

Address: _____ Relationship to Patient: _____

City: _____ SS #: _____

State: _____ Zip: _____ D.O.B.: _____

2. PHONE NUMBERS

Cell #: _____ Home #: _____ Work #: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____ Phone #: _____

3. DENTAL INSURANCE

Primary: MEDICAL ◯ DENTAL ◯ (Check One) Secondary: MEDICAL ◯ DENTAL ◯ (Check One)

Insured's Name: _____ Insured's Name: _____

SS/ID #: _____ D.O.B.: _____ SS/ID #: _____ D.O.B.: _____

Employer: _____ Employer: _____

Group #: _____ Group #: _____

Plan Name: _____ Plan Name: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Insurance Phone #: _____ Insurance Phone #: _____

4. DENTAL HISTORY

Reason For Visit: _____

Former Dentist: _____

City / State / Zip: _____

Date of Last Dental Visit: _____

Date of Last Dental X-Ray: _____

How Often Do You Floss? _____

How Often Do You Brush? _____

Please check YES or NO to indicate if you have had any of the following:

Bad Breath	◯ Yes	◯ No	Jaw Pain or Tiredness	◯ Yes	◯ No
Bleeding Gums	◯ Yes	◯ No	Loose Teeth or Broken Fillings	◯ Yes	◯ No
Blisters on Lips or Mouth	◯ Yes	◯ No	Mouth Breathing	◯ Yes	◯ No
Burning Sensation on Tongue	◯ Yes	◯ No	Mouth Pain	◯ Yes	◯ No
Cigarette, Pipe, or Cigar Smoking	◯ Yes	◯ No	Orthodontic Treatment	◯ Yes	◯ No
Clicking or Popping Jaw	◯ Yes	◯ No	Periodontal Treatment	◯ Yes	◯ No
Dry Mouth	◯ Yes	◯ No	Sensitivity to Temperature	◯ Yes	◯ No
Food Collection Between Teeth	◯ Yes	◯ No	Sensitivity to Sweets	◯ Yes	◯ No
Grinding Teeth	◯ Yes	◯ No	Sensitivity when Chewing	◯ Yes	◯ No
Gums Swollen or Tender	◯ Yes	◯ No	Sores or Growths in Mouth	◯ Yes	◯ No

5. MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Physician Phone #: _____ Pharmacy: _____ Phone #: _____

Please check YES or NO to indicate if you have had any of the following:

AIDS	◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Shortness of Breath	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Heart Problems	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Arthritis, Rheumatism	◯ Yes	◯ No	Hepatitis Type ____	◯ Yes	◯ No	Skin Rash	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Special Diet/Weight Loss	◯ Yes	◯ No
Back Problems	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	HIV Positive	◯ Yes	◯ No	Swollen Feet or Ankles	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No	Swollen Neck Glands	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Jaw Pain	◯ Yes	◯ No	Thyroid Problems	◯ Yes	◯ No
Circulatory Problems	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No	Tonsilitis	◯ Yes	◯ No
Cortisone Treatments	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cough, Persistent or Blood	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Tumor or Growths	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Nervous Problems	◯ Yes	◯ No	Ulcer	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No	Radiation Treatment	◯ Yes	◯ No			
Fainting or Dizziness	◯ Yes	◯ No	Respiratory Disease	◯ Yes	◯ No			
Glaucoma	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No			

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

If yes, please describe_____

_____

Have you ever been hospitalized or do you have any other health concerns? ◯ Yes ◯ No

If yes, please describe_____

_____

Women: Are you pregnant? ◯ Yes ◯ No

Due Date: _____

Are you nursing? ◯ Yes ◯ No

Taking birth control pills? ◯ Yes ◯ No

Have you ever taken any of these medications?

Blood Thinners	◯ Yes	◯ No
Coumadin	◯ Yes	◯ No
Warafin	◯ Yes	◯ No
Diet Medications	◯ Yes	◯ No
Dextenfluramine	◯ Yes	◯ No
Fen-Phen	◯ Yes	◯ No
Pondimin	◯ Yes	◯ No
Redux	◯ Yes	◯ No

Have you ever used bisphosphonate medication?

Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ◯ Yes ◯ No

Have you ever had or been diagnosed with:

Artificial Heart Valves	◯ Yes	◯ No
Artificial Joints, Screws, Pins	◯ Yes	◯ No
Abnormal Bleeding with Surgery	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Hernia Repair	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No

Are you allergic to:

Aspirin	◯ Yes	◯ No
Barbiturates	◯ Yes	◯ No
Codeine	◯ Yes	◯ No
Ibuprofen	◯ Yes	◯ No
Latex	◯ Yes	◯ No
Local Anesthesia	◯ Yes	◯ No
Metals (i.e. nickel)	◯ Yes	◯ No
Penicillin	◯ Yes	◯ No

Other:_____

Please PRINT all medications now taking:_____

Patient Signature: _____ **Date:** _____