

~ ~ **Welcome** ~ ~

About You

Today's Date: _____

Name: _____ I prefer to be called: _____
Last First M.I.

Birthdate: ____/____/____ S. S. #: ____ - ____ - ____ Drivers License: _____
State Number

Street Address: _____
and Street City State Zip

Mailing Address: _____
P. O. Box City State Zip

Home Phone # _____ Work # _____ Cell/Pager # _____

Email Address: _____ Preferred Method of Contact: _____

Employer & Address: _____ Occupation: _____

Spouse: _____ Work Phone: _____

Spouse Employer & Address: _____

How did you find out about our office? _____

Emergency Contact Person: _____

Relation: _____ Home Phone # _____

Address: _____
P. O. Box/Street City State Zip

Person Responsible for Account

Name: _____ Relationship: _____ S. S. #: ____ - ____ - ____

Address: _____

Home Phone #: _____ Work Phone #: _____

Insurance Information

Company Name: _____ Phone #: _____ Group #: _____

Address: _____
P. O. Box/Street City State Zip

Insured's Name # _____ S. S. # _____ Birthdate: ____/____/____

Insured's Employer: _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: _____ **Date:** _____

Patient Name _____

Medical History

Do you have a personal physician? Yes No

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

Address: _____ Phone #: _____
P. O. Box/Street City State Zip

Your current physical health is: Good Fair Poor Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever been involved with dental/medical legal activity Yes No

Are you allergies to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Sedatives |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list additional drugs that cause allergic reactions: _____

Are you taking any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Acetaminophen | <input type="checkbox"/> Y <input type="checkbox"/> N Blood Pressure Medication | <input type="checkbox"/> Y <input type="checkbox"/> N Recreation Drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Remedies | <input type="checkbox"/> Y <input type="checkbox"/> N Steroids/Cortisone |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antihistamines | <input type="checkbox"/> Y <input type="checkbox"/> N Digitalis/Heart Medication | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Medicine |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Insulin/Diabetes Drugs | <input type="checkbox"/> Y <input type="checkbox"/> N Tranquilizers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Thinners | <input type="checkbox"/> Y <input type="checkbox"/> N Nitroglycerin | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Are you taking any prescription/over-the-counter drugs not listed above? _____

Has any doctor recommended pre-medication with antibiotics before dental appointments for any reason? If so, please explain: _____

Do you have or have you experienced any of the following?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Counseling for excessive use of alcohol and/or prescribed drugs? | | | |

Please list any serious medical condition(s) you have experienced: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

VITAL INFORMATION ABOUT YOUR DENTAL INSURANCE

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatments on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. Pay fees not covered by your plan at the time of treatment.
2. Provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. Understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. Pay any account balance not paid by insurance after 2 billing attempts.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep one copy on your chart and will give you one copy for your records if requested.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient or Insured

Date

Robertsdale Dental Care
W. Jason Northcutt, D.M.D., P.C.
18471 Wilters Street
Robertsdale, AL 36567

FINANCIAL POLICY

All Patients

_____ I understand that payment for treatment is due at the end of the appointment. Payment for sedation surgery is due when the appointment is made.

_____ I understand that if I have no insurance coverage, I am responsible for the payment for services provided for myself or my dependents.

_____ Robertsdale Dental Care accepts cash, check, Visa, MasterCard, Discover, and American Express. Checks will be processed electronically. Please be aware there is a \$30.00 service fee for all returned checks.

_____ I understand that in the event my account is turned over to collections or for legal judgment or action, I am responsible for all reasonable attorneys' fees, court costs and associated costs with collections.

Patients with Insurance

_____ I understand that as a courtesy to me and upon my authorization, Robertsdale Dental Care will submit a claim to my primary dental insurance upon completion of treatment. I authorize payment(s) to go directly to Dr. W. Jason Northcutt. If I have secondary or tertiary insurance, it is my responsibility to file to that policy.

_____ Robertsdale Dental Care is a **preferred provider** (in network) of Blue Cross Blue Shield of Alabama. Although Dr. W. Jason Northcutt is considered an out of network provider to other private insurance companies, Robertsdale Dental Care is willing to file your claim if benefits are available.

_____ I understand that Robertsdale Dental Care does not file to Medicare or Medicaid.

_____ **Treatment plans are an estimate only based on information given from your insurance company.**
Upon final settlement of the insurance claim, any and all amounts of non-covered or denied services will be billed directly to me by Robertsdale Dental Care. I am responsible for contacting my insurance company regarding any disputes/discrepancies in payment.

_____ I understand that since certain Delta Dental insurance reimburses the patient and not the provider, payment may be due in full at time of appointment.

Signature of Patient or Responsible Party

Date

In the case of a minor, the individual that signs this document is responsible for payment.

Please let us know if you have any questions regarding our financial policy.

Missed Appointment Policy

We want to thank you for choosing us as your dental health provider. In order to provide you and other patients with the best optimal dental care, we request that you follow our guidelines regarding broken and/or cancelled appointments.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Failure to give 24 hours notice will result in a \$40 missed appointment fee.

We will call to remind you of your hygiene appointment 5 days prior. If we don't verbally hear from you within 48 hours, your appointment may be released to another person.

Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your dental office choice.

Signature: _____ Date: _____

ROBERTSDALE DENTAL CARE
W. Jason Northcutt, D.M.D.
Miriam Perdomo-Watts, D.M.D.
18471 Wilters St, Robertsdale, AL 36567

Privacy Agreement

Dr. Northcutt, Associates and Staff (collectively labeled Dentist) agree to maintain Privacy of our patients as outlined in this HIPAA form. The Dentist takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State Privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patient's best interest. Accordingly, Dentist agrees not to provide any list for marketing directly to patients. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Dentist has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Dentist: and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dentist's practice.

Dentist feels strongly about Patient's privacy as well as the practices' right to control its public image and privacy. Both Dentist and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to Patient; or (b) three years beyond any termination of the Dentist-patient relationship. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients.

Patient and Dentist acknowledge that breach of this agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient _____ Date _____

Patient Evaluation Form

1. On a scale of 1 to 5 (1 being bad, 5 being good) please rate how you feel your overall dental health is.

1 2 3 4 5

2. How healthy do you want us to get your mouth?

- Don't really care
- Average
- The best it can be

3. Rate how you feel about your smile and the look of your teeth. (1 being unhappy, 5 being very happy.)

1 2 3 4 5

4. Are you interested in regular hygiene cleanings?

- Yes No

5. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your level of sensitivity to dental procedures?

1 2 3 4 5

6. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your sensitivity during cleaning visits?

1 2 3 4 5

7. Do you have any family or friends that already come to our office?

8. What are your expectations today?

9. Has fear ever been an issue for you in the dental office?

10. What is the main reason for your visit today?

- Tooth pain
- I need a check-up
- Cleaning
- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Other _____

11. I would like to learn more about:

- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Implants
- Bridges
- Dentures
- Other _____

12. Is there any additional information you would like us to know?
