



New Patient Forms

We would like to get to know you better!

589 US 31 Hwy | Beulah | Michigan | 49617
231.882.4424 | www.northpinedental.com

Welcome! We are North Pine Family Dentistry. Because we are a family business who cares, we aspire to provide the best for you and your family. North Pine strives for clinical excellence, personalized care, patient comfort, and great customer service. Here, patients find it easy and convenient to receive quality customized dental care in a comfortable, family-friendly environment. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. The information provided on these forms is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask. We are excited you are joining our practice and we look forward to seeing you in our office soon!

Patient's Full Name: _____

Guardian (for Minor): _____ Male Female

Date of Birth: _____ Preferred to be called: _____

Single Married Separated Divorced Widowed Minor

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Other Household Members Joining Practice

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Other Household Members Currently at Practice:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize North Pine Family Dentistry to perform any necessary examination and radiographs needed for proper diagnosis.

Signature

Date

NORTH PINE FAMILY DENTISTRY MEDICAL HEALTH HISTORY

Patient: _____

Date of Birth: _____

Have you had any of the following?	Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
If so, how recent?_____		
Taking Heart Medication	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
If so, how recent?_____		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
What kind?_____		
How was it treated?_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of smoking?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD	<input type="checkbox"/>	<input type="checkbox"/>
HIV-Positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If so, for what?		

During the past 12 months, have you taken any of the following?	Yes	No
Anticoagulants or blood thinners (e.g. Warfarin, Eloquis, Xeralto, etc)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>

Please list current medication:	
Have you ever taken bisphosphonates? (e.g. Fosamax, Reclast, Prolia, Actonel, etc)	Yes No <input type="checkbox"/> <input type="checkbox"/>

Do you have any known drug allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> List below:
List any major surgeries:
Do you require antibiotic premedication prior to dental procedures? (e.g. for artificial joints or heart valves) Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Medical Doctor:_____
Any other concerns?

Women	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected due date_____		
Are you currently breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE QUESTIONS ABOVE AND I CERTIFY THAT ALL THE INFORMATION LISTED IS COMPLETE AND ACCURATE.

Patient's Signature _____

Doctor's Initials _____ Date: _____

NORTH PINE FAMILY DENTISTRY DENTAL HEALTH HISTORY

Patient: _____

Date of Birth: _____

Date of Last Dental Exam:
Date of Last Dental Cleaning:
Date of Last Dental X-Rays:
Former Dentist:

If you could change something about your smile, what would it be?	Yes	No
Whiter	<input type="checkbox"/>	<input type="checkbox"/>
Straighter	<input type="checkbox"/>	<input type="checkbox"/>
Close Spaces	<input type="checkbox"/>	<input type="checkbox"/>
Replace black fillings with white restorations	<input type="checkbox"/>	<input type="checkbox"/>
Repair Chipped Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Replace Missing Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Less Gums Showing	<input type="checkbox"/>	<input type="checkbox"/>
Replace old crowns or caps that don't match	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any of the following?	Yes	No
Oral Cancer Screening	<input type="checkbox"/>	<input type="checkbox"/>
Oral Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Temporomandibular (Jaw) Disorder (TMD)	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Chewing Food	<input type="checkbox"/>	<input type="checkbox"/>
Tender or Swollen Gums	<input type="checkbox"/>	<input type="checkbox"/>
Slow Healing Sores In or Around Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Hot	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Sweets	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Sour	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal Maintenance Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Complications From Tooth Extraction	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction to crown, metal filling or dental appliance	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind frequently?	<input type="checkbox"/>	<input type="checkbox"/>

<p>On a scale of 1 to 10, with 10 being the highest, how important is your dental health to you?</p> <p style="text-align: center;"> 1 2 3 4 5 6 7 8 9 10 </p>

<p>Are you aware of any unfinished treatment that was advised by a prior dentist? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>List below:</p> <hr/> <hr/>
<p>Any other concerns?</p> <hr/> <hr/>

	Yes	No
Are you apprehensive about dental visits/treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE QUESTIONS ABOVE AND I CERTIFY THAT ALL THE INFORMATION LISTED IS COMPLETE AND ACCURATE.

Patient's Signature _____

Doctor's Initials _____ Date: _____

**PAYMENT ARRANGEMENT FORM
NORTH PINE FAMILY DENTISTRY ("Practice")**

NAME OF PATIENT(S): _____ ("Patient(s)")

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient(s) and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment, that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to \$35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs related to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party:

Full Name: _____ DOB: _____ SSN# _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ ID Number: _____ Group Number: _____
Insurance Company Address: _____ Phone Number: _____
Name of Insured: _____ Relationship to Patient: _____

Secondary Insurance:

Primary Insurance Name: _____ ID Number: _____ Group Number: _____
Insurance Company Address: _____ Phone Number: _____
Name of Insured: _____ Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

(To be signed even if the Patient is also the Responsible Party)

North Pine Family Dentistry

589 US 31 Hwy | Beulah | Michigan | 49617

HIPAA & Notice of Privacy Practices

PATIENT DETAILS:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Gender: Male Female Prefer not to say

Marital Status: Single Married Separated Divorced Widowed Minor

If Patient is a Minor, Guardians Name: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: <https://www.hhs.gov/hipaa/for-individuals/index.html>. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.

You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years. We will provide such a list at no charge upon your request once in any 12 month period. We reserve the right to charge you for requests in excess of one per 12 month period.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

Patient Signature:

Date: