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:____

Date of Birth:__________Preferred to be called:________________ ☐ Male ☐ Female

☐ 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	☐	☐
Shortness of Breath	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
If so, how recent?______		
Taking Heart Medication	☐	☐
Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Stomach Ulcers	☐	☐
Kidney Disease	☐	☐
Fainting	☐	☐
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Sinus Problems	☐	☐
Asthma		
Arthritis	☐	☐
Joint Replacement	☐	☐
Seizures or Epilepsy	☐	☐
Stroke	☐	☐
If so, how recent?______		
Thyroid Problems	☐	☐
Cancer/Tumor	☐	☐
What kind?______		
How was it treated?______		
Diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol ?	☐	☐
Do you smoke?	☐	☐
Do you have a history of smoking?	☐	☐
Hepatitis or Liver Disease	☐	☐
Herpes or other STD	☐	☐
HIV-Positive/AIDS	☐	☐
Have you been hospitalized in the last 6 months?	☐	☐
If so, for what? ______		

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you currently pregnant?	☐	☐
If so, expected due date______		
Are you currently breastfeeding?	☐	☐

During the past 12 months, have you taken any of the following?	**Yes**	**No**
Anticoagulants or blood thinners	☐	☐
High blood pressure medicine	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐

Please list current medication:

Do you have any known drug allergies? Yes ☐ No ☐
List below:

List any major surgeries:

Do you require antibiotic premedication prior to dental procedures? (e.g. for artificial joints or heart valves)
Yes ☐ No ☐

Any other concerns?

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:

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

	Yes	**No**
Are you apprehensive about dental visits/ treatment?	☐	☐
Have you had any problems with previous dental treatment?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐

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

On a scale of 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Are you aware of any unfinished treatment that was advised by a prior dentist? Yes ☐ No ☐
List below:

Any other concerns?

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
CHILD HEALTH AND DENTAL HISTORY

Patient: **Parent:** **Date of Birth:**

Medical History	**Yes**	**No**
Is the child in good health?	☐	☐
Is the child under the care of a physician?	☐	☐
Name of Physician___________________		
Is the child receiving any medication?	☐	☐
Has the child ever had any serious illness?	☐	☐
If so, when and what?___________________		
Has the child ever been hospitalized?	☐	☐
If so, when and why?___________________		
Does the child have any allergies?	☐	☐
Is the child scheduled for any surgery?	☐	☐
If so, when?___________________		

Has the child had any of the following?	**Yes**	**No**
Diabetes	☐	☐
Heart Trouble	☐	☐
Asthma	☐	☐
Kidney infection or disease	☐	☐
Rheumatic fever	☐	☐
Toothaches	☐	☐
Frequent ear infections	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Nervous disorders	☐	☐
Abnormal bleeding	☐	☐

Please list current medication:

Dental History	**Yes**	**No**
Is this the child's first visit to the dentist?	☐	☐
If not, date of last visit?___________________		
Has the child had a dental cleaning before?	☐	☐
If so, date of last visit?___________________		
Does the child eat sweets (candy, soda, gum)	☐	☐
Do you live in an area with fluoridated water?	☐	☐
Has the child's teeth been treated with fluoride?	☐	☐
Have cavities been noted in the past?	☐	☐
Were any teeth removed by extraction?	☐	☐
Was it suggested that space be maintained?	☐	☐
Was an application placed?	☐	☐
Have there been any injuries to teeth? (e.g. chips, blows, falls, etc)	☐	☐
If so, describe:___________________		
Has the child had any unfavorable dental experiences?	☐	☐
If so, describe:___________________		
Has the child ever received anesthetic?	☐	☐

Do you have any known drug allergies? Yes ☐ No ☐
List below:

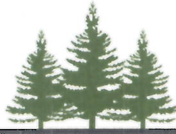
List any major surgeries:

Any other concerns?

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

Parent's Signature___________________

Doctor's Initials______________ Date:______________



JOSHUA BRUDI DDS
231.882.4424

Records Transfer Request

X-Ray Release Request

I authorize ________________________________ to copy my x-rays and records and mail to: North Pine Family Dentistry

589 US 31 Hwy.

Beulah, MI 49617

Or Email to: northpinedental@gmail.com

Name of Patient:__________________________________Date of Birth:_________

Signature of Patient or Guardian:____

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.

Copyright@2021 SRS Web Solutions Inc. www.mconsent.net - Updated: 3/31/2021 Rev:02

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 6years. 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:**

Copyright@2021 SRS Web Solutions Inc. www.mconsent.net - Updated: 3/31/2021 Rev:02

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.

Copyright@2021 SRS Web Solutions Inc. www.mconsent.net - Updated: 3/31/2021 Rev:02