NORTHCHASE
FAMILY DENTISTRY

PATIENT INFORMATION

Patient Name: _____ Date: _____
Male ____ Female ____ Date of birth: _____ Social Security Number: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____ Apt#: _____
City: _____ State: _____ Zip code: _____ Email: _____

If patient is a child Parent/Guardian Name: _____
How did you hear about our office? _____

PATIENT HEALTH INFORMATION

What are you allergic to? _____

Have you ever taken a medication for your bones (bisphosphonates)? YES ___ NO ___
Do you have any artificial heart valves? YES___ NO___
Do you have any artificial joints? YES ___NO ___
Do you use any tobacco products? YES ___ NO ____ What?_____ How long?_____
Do you use any recreational drugs? YES ___ NO ___
Are you taking any blood thinners? YES___ NO___
Have you taken any steroid medications in the past three months? YES ____ NO ____

Ladies: Are you pregnant? _____ Due Date: _____

Have you ever had any of the following? Please check all that applies:

HIV/AIDS____
Arthritis_____
Asthma _____
Blood Disease ____
Cancer _____
Diabetes _____
Epilepsy _____
Excessive Bleeding _____
Glaucoma ____
Heart Disease ____
Heart Murmur ____
Hepatitis ____
High Blood Pressure _____
Kidney Disease _____
Liver Disease _____
Pacemaker ____
Radiation Treatment _____
Rheumatic Fever _____
Stroke _____
Thyroid Disease____
Tuberculosis ____
Tumors ____
Ulcers ____
Venereal Disease _____
Other: _____
_____

List Medications currently taking: _____
_____

If applicable, I grant Northchase Family Dentistry permission to file my dental insurance on my behalf. I understand that I am responsible for all charges incurred at each dental appointment. I agree to be responsible for any balance remaining on my account after applicable insurance payments are received and applied to my account. Any balance that my insurance has not paid after 45 days of being filed will be my responsibility to pay in full. My dental insurance is a contract between myself and my insurance company--they make the rules for my policy, I have agreed to them, and this office plays no role in the details of my individual policy or if my insurance company does not fulfill it's obligations. **My insurance company dictates how much my covered treatment will cost and what my portion will be, not this office.** I agree that this office reserves the right to send any unpaid balances to collections, small-claims court, or file a 1099 in my name as unearned income to the IRS.

_____ _____
Signature of patient, parent or guardian Date

_____ _____
Signature of guarantor of payment/responsible party Date

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2709 Northchase PKWY SE
Wilmington, NC 28405
910-620-7356 Office
910-623-2140 Fax

MISSED APPOINTMENT POLICY

Any time that we make an appointment, we are reserving that time just to see you. In the event that you need to reschedule your appointment, **YOU MUST PROVIDE US WITH AT LEAST A 48 HOUR NOTICE**. An appointment is considered missed if you call in and cancel less than two full working days before the appointment, or do not show for the appointment, ***REGARDLESS OF THE REASON***. Cancellations must be made by calling the office directly.

If you miss any appointment, REGARDLESS OF THE REASON, a $100 no-show fee may be charged to you, and/or we may refuse to schedule any appointments in advance, requiring that you call on a day that you know you can come, to see if we will be able to fit you into our schedule.

I have read, understand, and will honor this agreement with Northchase Family Dentistry.

_____ _____

Patient or Guardian Signature Date

_____ _____

Team Representative Date

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NITROUS OXIDE SEDATION CONSENT

Patient Name: _____

Introduction: Nitrous oxide is colorless, slightly sweet gas that is used during dental treatment for relaxation and anxiety relief. When inhaled, it can induce feelings of euphoria and sedation. It can also produce sensations of drowsiness, warmth, and tingling in the hands, feet and/or about the mouth. In the dental setting, it will not induce unconsciousness. You will be able to swallow, talk, and cough as needed.

Contraindications:
Please let us know if you have any of the following medical conditions because we may not be able to safely use nitrous oxide

___ Congestive Heart Failure
___ Middle-ear infections
___ Chronic Asthma
___ Chronic bronchitis
___ Claustrophobia
___ History of substance abuse
___ Emphysema
___ Respiratory disease
___ Bronchiectasis
___ Macrocytic anemia
___ Chronic obtrusive Pulmonary disease-**COPD**
___ Pregnancy
___ Immune Disease
___ Hepatitis B or C
___ Tuberculosis

Preoperative guidelines: Nitrous oxide is administered through a nasal mask. You must be able to breathe through the nose (blocked nasal passage, colds, etc. defeat the idea of using nitrous oxide). Nitrous oxide may cause "stomach butterflies" (nausea), which may result in vomiting.

Instructions: Your mask must remain firmly in place, do not breathe through your mouth, breathe through your nose only. Talking while receiving nitrous lessens the desired effects for you. You may feel nauseated, dizzy or claustrophobic during and after the sedation.

Post procedure guidelines: Recovery from nitrous is rapid. The gas will be flushed from your system with oxygen. If you feel dizzy after the sedation, remain seated. The sensation usually passes in a few minutes. Do not leave the office until you feel clear and able to function (i.e., walk and drive) safely.

I understand the above statements and have had my questions answered.

Accept Nitrous: _____ **Initials:** _____
Decline Nitrous: _____ **Initials:** _____

_____ _____
Patient/Guardian if patient is a minor **Date**

_____ _____
Witness **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

By signing this, you acknowledge receipt of the Notice of Privacy Practices from Northchase Family Dentistry. The Notice of Privacy Practices information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy on request from our staff.

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

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency prevented us from obtaining acknowledgement
____ Other (please specify_____