North Point Dental Associates

www.northpointsmiles.com
6425 Old Plank Rd | Suite 102 • High Point, NC 27265 (336)886-1747

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Company Address and Phone Number:

_____

_____

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ AIDS/HIV
☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro
☐ Allergy - Hay Fever	☐ Allergy - Iodine	☐ Allergy - Latex	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy-Barbiturates	☐ Anemia
☐ Arthristis, Rheumati	☐ Artificial Joints	☐ Asthma	☐ Back Problems
☐ Bleeding Abnormally	☐ Blood Disease	☐ Cancer	☐ Chemical Dependency
☐ Chemotherapy	☐ Circulatory Problems	☐ Congenital Heart Les	☐ Cortisone Treatments
☐ Cough, persistent	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fainting or Dizzines	☐ Headaches	☐ Heart Murmur	☐ Heart Problems
☐ Hepatitis Type	☐ Herpes	☐ High Blood Pressure	☐ Jaw Pain
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Mitral Valve Prolaps
☐ Nervous Problems	☐ Pacemaker	☐ Psychiatric Care	☐ Radiation Treatment
☐ Respiratory Disease	☐ Rheumatic Fever	☐ Scarlet Fever	☐ SEE LIST OF MEDS
☐ SEE MEDICAL HISTORY	☐ Shortness of Breath	☐ Sinus Trouble	☐ Skin Rash
☐ Special Diet	☐ Stroke	☐ Swollen Feet or ankl	☐ Swollen Neck Glands
☐ Thyroid Problems	☐ Tonsillitis	☐ Tuberculosis	☐ Tumor or growth

☐ Ever been hospitalized (illness or injury)	☐ Presently being treated for any other illnesses
☐ Taking medication for weight control (ie fen-phen)	☐ Taking dietary supplements
☐ Subject to frequent headaches	☐ A smoker or smoked previously
☐ FEMALE: Taking birth control pills	☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Name of your physician and your most recent physical exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List all PRESCRIBED medications:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Dental Information

Previous Dentist name and how long have you been a patient there:

Date of most recent exam/dental x-rays: _____

No Show and Reschedule Policy

A "No Show" is a patient who FAILS to keep a scheduled appointment without notifying us or who reschedules with less than 24 hours notice. We understand that unavoidable circumstances sometimes cause patients to miss appointments. Therefore ;

1. The first "No Show" occurrence is noted in the patients chart. You will also receive a letter in the mail concerning the missed appointment.
2. After the second "No Show" occurrence, a deposit must be made to hold the next appointment time.
3. At that third "No Show" the deposit will be retained by North Point Dental Associates and another deposit must be made for all appointments.

We may need to reschedule your appointment for the following reasons;

1. If you are more than 10 minutes late for your appointment.
2. In consideration of the health of our other patients and staff, if you are sick.
3. If you fail to bring your co-pay if one is required.

Thank you for your understanding and cooperation.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA CONSENT FORM

Patient information will be maintained by North Point Dental Associates as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with the federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by contacting our office.
We reserve the right to:
Call and remind you of your next appointment and/or to leave information on your voicemail or with the person whom answers your phone.
Call you with information pertaining to your dental treatment/care and leave a message on your voicemail.
Check each person/entity that you approve to receive information:

☐ **Spouse**

Provide Name:

_____

_____

☐ **Parent**

Provide Name:

_____

_____

☐ **Other**

Provide Names:

_____

_____

☐ ***I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.**

☐ ***I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.**

☐ ***I understand this authorization shall be in effect until revoked by the patient.**

OSHA Compliance

Due to OSHA regulations in order to maintain a safe and distraction free enviroment, only patients with and appointment will be allowed beyond the waiting room.

All children without an appointment must have adult supervision and are to wait in the lobby until the patient being seen has completed their visit in our office.

Thank you for your understanding and cooperation.

☐ * **I understand and will comply to these rules.**

COVID-19

Do you/they have a fever or you/they felt hot or feverish recently (14-21) days? *
◯ Yes ◯ No

Are you/they having shortness of breath or other difficulties breathing? *
◯ Yes ◯ No

Any flu-like symptoms, such as gastrointestinal upset, headache or fatigue? *
◯ Yes ◯ No

Do you currently have a cough? * ◯ Yes ◯ No

Have you/they experienced recent loss of taste or smell? * ◯ Yes ◯ No

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Are you/they in contact with any confirmed COVID-19 individual, OR in contact with someone experiencing symptoms? * ◯ Yes ◯ No

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Have you/they traveled in the past 14 days by air, bus, or train? *
◯ Yes ◯ No

Have you been tested for COVID-19 in the LAST 21 days? * ◯ Yes ◯ No

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I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate. *

◯ Yes ◯ No

COVID-19 NOTICE AND ACKNOWLEDGEMENT OF RISK

☐ * **Our goal at North Point Dental Associates is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.**

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

COVID-19 has a long incubation period. You or all your health care providers may have the virus and not show symptoms and yet still be highly contagious. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus by simply being in a dental office.

Dental procedures create water spray which is one of the ways the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract COVID-19 virus from outside this office and unrelated to my visit here.

I have read and fully understand the information stated above. ◯ Yes ◯ No

Response Date: _____