9735 KINCEY AVE, STE 206, HUNTERSVILLE, NC 28078
Website: northstardentistryforadults.com
Phone: 704-450-6500
FAX: 704-274-5484

PATIENT INFORMATION

DATE_____

FIRST NAME_____LAST NAME_____

PATIENT'S Date of birth_____SS#_____

IF CHILD PARENT OR GUARDIAN'S NAME_____

ADDRESS 1_____

ADDRESS 2_____

CITY_____STATE_____ZIP _____

HOME PHONE_____CELL_____

EMAIL ADDRESS:_____

BEST METHOD OF CONTACTING YOU:_____

REFERRED BY:_____

Why did you choose NorthStar as your dental office?_____

Has any member of your family been treated in our office previously? ---------- Yes/ No If yes, Relationship_____

PLEASE CIRCLE—SINGLE MARRIED DIVORCED WIDOWED

Responsible person for account: SELF
OTHER: PLEASE LIST:_____SS#_____

Emergency Contact Information:
Name_____Relationship_____

Contact Number:_____

NORTHSTAR
DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

DENTAL HISTORY

Are you currently having dental discomfort? If yes, explain: Yes/No

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The most important concerns regarding my dental health are:_____

Please list any additional concerns or comments: _____

Dental Health (Please circle one) Excellent Good Fair Poor

What priority do you give your teeth (10 being the highest) 1 2 3 4 5 6 7 8 9 10

Please Circle:
Do you have any missing teeth? ----------Yes / No
Have missing teeth been replaced?----------Yes/ No
Orthodontic appliances now or in the past?----------Yes/ No
Gums bleed when brushing or flossing? ----------Yes/ No
Are you concerned about gum disease? ----------Yes/ No
Any history of gum disease? ----------Yes/ No
Does it hurt to bite or chew? ----------Yes/ No
Do you clench or grind your teeth?----------Yes/ No
Do you want your mouth properly restored and pain free?----------Yes/ No

Do you have any concerns about the appearance of your teeth?_____

Please circle one:

1. A) I think the appearance of my mouth is excellent.
   B) I am satisfied with the appearance of my mouth.
   C) I am dissatisfied with the appearance of my mouth.

2. A) I will do anything to keep my natural teeth.
   B) I want to keep my natural teeth, but have a certain budget of time and money that I am willing to spend on them.
   C) I don't care whether I keep them or not.

3. A) I have set goals for my oral health with a previous dentist.
   B) I want to set goals concerning my dental health.
   C) I have never set goals concerning my oral health.

4. A) I do exactly what is recommended for my dental health.
   B) I have done what dentists have recommended for my mouth.
   C) I rarely go and don't care much about having my dental work completed.

What will be the most important factors for your satisfaction with our office?

PREVIOUS DENTAL OFFICE INFORMATION:

Dentist Name_____

Practice Name_____PracticePhone#_____

Date of last Panoramic X-ray _____

Date of last Bitewing X-ray 4flm _____

Signature_____Date_____

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MEDICAL INFORMATION

DATE_____

MEDICAL HISTORY:

Primary Care Physician's Name _____

Practice Name _____PhoneNumber_____

Are you currently under a physician's care ----------Yes / No
Have you been hospitalized in the last 5 years?----------Yes / No
Any serious illnesses or surgeries ----------Yes / No
Do you use tobacco in any form? Yes/ No If yes, explain: _____

Do you have to pre-medicate before your dental appt due to heart condition or artificial joints?-----Yes/No if yes, what medication do you take and dosage _____

Do you know of any reason why routine dental procedures might post a risk to you, our staff, or other patient's? ---Yes/ No If yes, explain:_____

If there is any important medical condition(s) we need to be aware of please describe:

Are you taking any prescription or daily OTC medications/drugs?—Yes/ No
If yes, List in Medication Section

Have you ever had COVID-19? —Yes/No

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER'S
- ☐ BLEEDING DISORDER
- ☐ BULIMIA
- ☐ CANCER/MALIGNANCY
- ☐ CEREBRAL PALSY
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS/FAINTING
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT HEADACHES
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ MITRAL VALVE PROLAPSE
- ☐ MONONUCLEOSIS
- ☐ PACEMAKER
- ☐ OTHER – PLEASE LIST:
- ☐ PSYCHIATRIC TREATMENT
- ☐ RADIATION/CHEMO
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

- ☐ ASPIRIN
- ☐ ANESTHETIC – LOCAL
- ☐ BARBITURATES
- ☐ OTHER – PLEASE LIST:
- ☐ CODEINE
- ☐ DAIRY
- ☐ LATEX
- ☐ LACTOSE INTOLERANCE
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS
☐ ANTIHISTAMINES/ALLERGY
☐ DAILY ASPIRIN
☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS
☐ CANCER/CHEMO MEDICATIONS
☐ CORTISONE/STEROIDS
☐ HEART MEDICATION/DIGITALIS
☐ INSULIN
☐ NITROGLYCERIN
☐ ORAL CONTRACEPTIVES
☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS
☐ RECREATIONAL DRUGS
☐ THYROID MEDICATIONS
☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

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PHOTOGRAPHY RELEASE

I, _____,

hereby authorize NorthStar Dentistry for Adults to take photographs and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs and/or videos will be used as a record of my care and may be used for educational purposes in study club meetings, lectures seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential.

I will allow NorthStar Dentistry for Adults to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures and further will allow them permission to discuss my conditions with my physician and to request medical information from my physician.

I do not expect compensation, financial or otherwise, for the use of these photographs.

SIGNATURE_____

DATE_____

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DENTISTRY FOR ADULTS
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FINANCIAL GUIDELINES

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network with most major insurance plans.**
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** –
-
- **Payment Information:**
  - **All major credit cards are accepted (Visa, MasterCard, Discover, American Express,)**
  - **Various financing options with CareCredit®**
  - **Compassionate Healthcare Services**
- **Balances left over 90 days will incur a monthly late fee of 1 1/2% interest.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Our goal is to honor your time by staying on time unless there is an emergency—we sincerely ask our patients to honor our time as well.

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By signing below I acknowledge I have read and understand the guidelines above.

Signature_____Date_____

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DENTISTRY FOR ADULTS
CARING + HEALTH + ARTISTRY

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Purpose of Release: ☐ Ongoing Communications ☐ Copy of Records ☐ Legal or Insurance Review ☐ Authorized Representative's Request ☐ Other

NAME OF PATIENT FOR WHOSE INFORMATION IS TO BE RELEASED:

NAME_____DOB_____PH:_____

ADDRESS:_____City/State/Zip_____

EMAIL ADDRESS:_____

RELEASE INFORMATION: ☐FROM ☐TO

The Facility/Practice/Individual listed below is authorized to release my Health Information.

Physician/Dentist Name:_____
___
Practice Address:_____

Practice Email Address:_____

Practice Phone:_____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:
☐ALL RECORDS AND DETAILS ☐ PANORAMIC X-RAY ☐BITEWINGS ☐PERIO CHART ☐CLINICAL NOTES

☐OTHER_____

RELEASE HEALTH INFORMATION: ☐ TO ☐FROM

NorthStar Dentistry for Adults
Dr. David Bunn
9735 KINCEY AVE, SUITE 206
HUNTERSVILLE, NC 28078
PH: 704.450.6500
FAX: 704-274-5484
EMAIL: info@northstardentistryforadults.com

☐ RELEASE TO MYSELF AT ABOVE ADDRESS
PATIENT'S SIGNATURE_____DATE_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____**Date:**_____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

_____

☐ I give permission for the following communications to be used by NorthStar Dentistry For Adults **(please check all that apply)** :

☐ Cell phone: ☐Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for NorthStar Dentistry For Adults to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for NorthStar Dentistry for Adults to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply):**

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children

_____

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to NorthStar Dentistry for Adults of the dental benefits otherwise payable to me.

I hereby authorize NorthStar Dentistry for Adults to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature_____Date_____