NADG

PATIENT INFORMATION

Personal Information:		
Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:	Home Phone:	E-mail:

Primary Insurance Information:	Secondary Insurance Information:
Insurance Carrier:	Insurance Carrier:
Insurance Carrier Phone:	Insurance Carrier Phone:
Employer:	Employer:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Member ID:	Member ID:
DOB:	DOB:
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Emergency Contact Information:		
Name of Contact:		
Phone Number:		
Relationship to Patient:		
May we communicate information with this individual concerning your care?	☐ Yes	☐ No

Physician and Pharmacy Information:	
Physician Name:	Phone Number:
Street Address:	City/State/Zip Code:
Date of Last Visit:	
Reason for Last Visit?	
Pharmacy Name:	Phone Number:
Street Address:	City/State/Zip Code:

Dental Information:	
Prior Dentist Name:	
Date of Last Visit?	Date of Last X-rays?
Reason for Today's Visit:	

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

Last Name: _____ First Name: _____ DOB: _____ Health History Form

Dental and Medical Health History:

Please indicate if you currently have or have had any of the following. Checking the box indicates "Yes", leaving blank indicates "No".

Dental Conditions
- ☐ **Bad Breath**
- ☐ **Blisters on Lips or Mouth**
- ☐ **Burning Sensation on Tongue**
- ☐ **Chew on One Side of Mouth**
- ☐ **Clench or Grind Teeth**
- ☐ **Dry Mouth**
- ☐ Food Collection Between Teeth
- ☐ Growths or Sore Spots in Your Mouth
- ☐ Gums Swollen, Tender or Bleeding
- ☐ Head/Neck/Jaw Pain or Aches
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Nitrous Oxide
- ☐ Periodontal Treatment
- ☐ Sensitivity to Pressure/Cold/Heat/Sweets
- ☐ Smokeless Tobacco
- ☐ Cigarette, Pipe, or Cigar Smoking

If yes, Frequency: _____ Quantity: _____

Allergies
- ☐ **Aspirin**
- ☐ **Latex**
- ☐ **Penicillin**
- ☐ **Other Allergies (List Below)**

Medical Conditions
- ☐ **Abnormal Bleeding**
- ☐ **Anemia**
- ☐ **Arthritis, Rheumatism**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints**
- ☐ **Asthma:**
  Required Hospitalization ☐
  Have you used steroids? ☐
  Date of Last Episode
  _____
- ☐ **Blood Transfusion**
- ☐ Blood Disease, Clotting Disorder
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, Persistent or Bloody
- ☐ Diabetes: A1C _____
  Date Taken _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis: Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any Immune Deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pregnant/Nursing:
  Due Date _____
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ **Sinusitis**
- ☐ **Shortness of Breath**
- ☐ **Sinus Trouble**
- ☐ **Sickle Cell Anemia**
- ☐ **Skin Rash**
- ☐ **Slow Healing Wounds**
- ☐ **Stroke**
- ☐ **Swelling of Feet or Ankles**
- ☐ **Thyroid Problems**
- ☐ **Tonsillitis**
- ☐ **Tuberculosis**
- ☐ **Tumor or Growth on Head and/or Neck**
- ☐ **Ulcer**
- ☐ **Venereal Disease**
- ☐ **Weight Loss, Unexplained**
- ☐ **Other Conditions (Explain Below)**

Other Allergies: List all additional allergies you have below.

Other Conditions: List all additional conditions or information below.

Medications: List any medications you are taking below.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Premedication ☐ **Yes** ☐ **No**
Do you have to take pre-medication prior to receiving dental treatment? If Yes, please explain:

Anesthetic Allergy ☐ **Yes** ☐ **No**
Have you ever had an allergic reaction to Novocaine, local or general anesthetics? If Yes, please explain:

Joint Replacement ☐ **Yes** ☐ **No**
Have you had an orthopedic total joint (hip knee, replacement? If Yes, have you had any complications?

Bisphosphonates ☐ **Yes** ☐ **No**
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Boniva, Reclast, Prolia, Didronel, Zometa) for osteoporosis or Paget's Disease?

Do you use controlled substances (drugs)? ☐ **Yes** ☐ **No**
If Yes, please specify what how often below:

Do you drink alcoholic beverages? ☐ Yes ☐ No
If Yes, how much alcohol did you drink in the last 24 hours? _____
If Yes, how much do you typically drink in a week? _____

Have you ever had trouble from previous dental care? ☐ **Yes** ☐ **No**
If Yes, please explain:

Authorization and Release: I have read and answered the above questions to the best of my knowledge.

_____ _____
Patient or Guardian Signature Date

_____ _____
Doctor Signature Date

Last Name: _____ First Name: _____ DOB: _____

Privacy Policy | Notice of Information & Privacy Practices | HIPAA Communication Form

By signing this form, you acknowledge that you have received a copy of Professional Dental Alliance practice ("Practice", "we", "us"), *Notice of Information and Privacy Practices* ("Notice"), which describes how your health information is used and shared. You understand that the Practice has the right to change this Notice at any time. You may obtain a current copy by contacting the Privacy Officer at compliance@nadentalgroup.com or by visiting the Practice's web site.

Patient privacy is important to us. Our policy is to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise permitted or required by federal or state privacy laws.

Please provide the names of individuals with whom we can communicate concerning you or your child's health information and care. This may include family members, friends, organizations, caregivers, and babysitters. This authorization will continue until it is revoked in writing by you. You may revoke this authorization in writing at any time.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information. If you have a family account, we may share information about your treatment to family members who are part of the family account for payment purposes.

Patient Communication - Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other healthcare related and billing information via text message, email or phone. These messages may come from an automated notification system. Limited information will be left when leaving a voice message. Medical information will not be shared when leaving a voice message. In addition to the aforementioned messages, we will communicate with you through text message from an automated patient notification system regarding your dental bill, surveys regarding your dental care, services or products related to your dental care or other communications related to your dental care and our practice. Please inform our team if you would prefer that we use an additional communication method for appointment reminders or other information related to your care.

Your signature below acknowledges that you have been provided with a copy of the Notice of Information and Privacy Practices and that you authorize the sharing of you or your child's health information with the individuals listed above. By providing us with your phone number(s) and/or email address, you consent to receive messages, including appointment reminders and other health-care related information by text message, voicemail, and email to the phone number(s) and email address that you have chosen to provide below:

Mobile Phone Number | Home Phone Number | Email Address

Print Name and/or Representative's Title (*e.g., Guardian, Executor of Estate, Health Care Power of Attorney)*

Patient or Guardian Signature | Date

Last Name: _____ First Name: _____ DOB: _____

Financial Agreement

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of the terms of this Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, Financial Agreement, or your responsibility.

- All patients must complete our "Patient Information Form" prior to being seen by the dental professional
- Full payment of your estimated co-insurance, co-payment, deductible, and/or non-covered service fee ("Charge") is due at the time of service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT

Payment

- You agree to pay in full any estimated Charge provided to you for your treatment or, if you are the parent or guardian of a minor patient, for the treatment of that patient.
- Amounts that remain due for dental care services provided to you and your family members, which shall include your spouse and children, will be charged to a consolidated family account ("Account"), unless you or a family member specifically instruct us otherwise. You promise to pay us all amounts due and owing on your Account (your "Balance") pursuant to the terms of this Financial Agreement when billed.
- The adult accompanying a minor, or, if the minor is unaccompanied, the parent or legal guardian of the minor is responsible for payment in full at the time of service. Non-emergency treatment of minors will be denied unless charges have been pre-authorized. Providers may choose to avoid treating a minor without an adult present at his or her own discretion.
- If your treatment includes procedures that require multiple visits and you abandon the treatment, we may charge a partial or full fee for the procedure.

Insurance

- If you have dental insurance, the Practice will bill your insurance company as a courtesy. In such case, you agree to assign your right to receive payment from the insurance company to us, unless your insurance requires us to file a medical claim prior to filing a dental claim. If your insurance company pays you instead of us, you are responsible for the Balance and agree to pay the Balance immediately. You also hereby authorize the release of any information related to your health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- We will estimate the amount you owe for a particular dental service at the time of service based on the amount anticipated to be paid by your insurance company. This amount may be subject to adjustment when the dental service claim is adjudicated by the insurance company based on the insurance company's policies, which may include (1) annual limitations on the amount of dental services that can be reimbursed within each plan year; (2) policies that require the least costly alternative service to be provided to treat a condition; (3) limitations on the age of patients for which a service is covered (e.g., noncoverage of fluoride treatments for adults); (4) services not covered under your dental plan; and (5) noncoverage of services considered cosmetic in nature or that are determined not medically necessary in a specific case.
- If your insurance company disallows a claim or only pays a portion of the amount owed for services, payment of your Balance is your responsibility. You are responsible for monitoring the amount of remaining benefits for any annual benefit period and may not rely upon any information provided by the staff regarding your remaining benefits in any such benefit period.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. However, you may be responsible for contacting such insurance companies to establish which dental carrier is primary.

Returned Payment Fee

- All payment returned due to non-sufficient funds may be subject to a returned payment fee of $20.00.

Collections and Collection Costs

- If we do not receive payment pursuant to the terms of this Financial Agreement and we refer your Balance to a collection agency or an attorney for collection, you agree to reimburse us the associated collection fees, which may be based on a percentage at a maximum of 15% of the Balance. You will also be responsible for all costs and expenses, including reasonable attorneys' fees, that we incur in such collection efforts, as permitted by applicable state law.
- By signing this Financial Agreement and providing your phone number and email address, you agree that the Practice (together with our affiliates, agents, contractors, and partners) may contact you by email, phone or text message for any purpose, including calls or texts placed using automatic telephone dialing system or an artificial or prerecorded voice. This includes (but is not limited to) texts or calls for marketing or debt collection purposes. You understand that this consent is not a condition of our provision of treatment to you. To opt-out of these messages, respond to a text with "STOP," call [insert phone number] or send an email to [insert email address]. Message and data rates may apply.

Credit Reports

- We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your Account to credit reporting agencies in accordance with applicable laws. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the above address.

Patient or Guardian Signature

Date

Patients, please keep this page for your records

Non-Discrimination Policy

Professional Dental Alliance and its affiliates comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Professional Dental Alliance and affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If requested, Professional Dental Alliance and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as: Qualified interpreters or Written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, contact the Office Manager at the practice location.

If you believe that Professional Dental Alliance and affiliates have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax or email with:

Compliance Manager
125 Enterprise Dr, Suite 200
Pittsburgh, PA 15275
724.698.2967
compliance@nadentalgroup.com

If you need help filing a grievance, Sheila Sarabia, Compliance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW; Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ADA Rights and Responsibilities Statement

Patient Rights: You have a right to:

1. Choose your own dentist and schedule an appointment in a timely manner.
2. Know the education and training of your dentist and the dental care team.
3. Request to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. Have adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. Know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. Receive an explanation of the purpose, probable (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. Be informed of continuing heath care needs.
8. Know in advance the expected cost of treatment.
9. Accept, defer, or decline any part of your treatment recommendations.
10. Have reasonable arrangements for dental care and emergency treatment.
11. Receive considerate, respectful, and confidential treatment by your dentist and dental team.
12. Expect the dental team members to use appropriate infection and sterilization controls.
13. Inquire about the availability of processes to mediate disputes about your treatment.
14. Receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

Patient Responsibilities: You have a responsibility to / for:

1. Provide, to the best of your ability, accurate, honest, and complete information about medical history and current health status.
2. Report changes in your medical status and provide feedback about your needs and expectations.
3. Participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. Inquire about treatment options and acknowledge the benefits and limitations of any treatment that you choose.
5. Consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. Keep your scheduled appointments.
7. Be available for treatment upon reasonable notice.
8. Adhere to regular home oral health care recommendations.
9. Assure that your financial obligations for healthcare are met.

Areas within practice may be limited to some requests for accommodations where sterile environment must be maintained.