PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____)_____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City_____ State _____ Zip_____

E-mail_____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation _____

Business Address _____ Business Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security #_____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies
☐ Arthritis
☐ Artificial Heart Valves or Joints, Screws, etc
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chronic Diarrhea
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Diabetes
☐ Epilepsy
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stroke
☐ Swollen Neck Glands
☐ Ulcer
☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what?_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time?_____ If so, what?_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

NORTH SHORE PERIODONTICS & IMPLANTOLOGY, LTD.
ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Our office makes every effort to maintain current information on the level of benefits provided by insurance carriers. However, insurance benefit levels, deductibles, co-pays, co-insurance and the need for authorizations and/or referrals are in a constant state of change.

Ultimately, the relationship between you and your insurance carrier is your responsibility. Accepting assignment does not mean that your responsibility for deductibles, co-pays, co-insurance and the need for authorizations and/or referrals are waived. In fact, providers who routinely waive these payments may be committing insurance fraud. Accordingly, your portion of the fee is DUE AT THE TIME OF SERVICE. For your convenience we accept cash, personal checks, Visa, MasterCard and Discover.

We accept assignment in good faith. After 3 months, if your insurance company denies or delays payment to us for any reason for services we have provided to you, then you will be responsible for paying the balance. Although we verify insurance coverage, it is not a guarantee of payment.

If you are not covered by a dental insurance plan, PAYMENT IN FULL is expected at time of service, unless prior arrangements have been made.

I have read the above statement of financial responsibility and wish to have periodontal services provided to me by North Shore Periodontics & Implantology, Ltd.

_____

Patient or responsible party Date

DENTAL INSURANCE INFORMATION

Patient's Name:_____

Patient's SS#:_____Birthdate:_____

Subscriber's Name:_____Relationship:_____

Subscriber's SS#/ID#:_____Birthdate:_____

Name of Insurance Co:_____

Address:_____

_____

Phone #:_____Group #:_____

NORTH SHORE PERIODONTICS & IMPLANTOLOGY, LTD.
FINANCIAL POLICY

METHODS OF PAYMENT
Cash
Check
Credit Card (Visa, MasterCard, Discover)

North Shore Periodontics & Implantology, Ltd. makes every effort to keep your fees in our office reasonable. We offer a 5% discount on SURGICAL TREATMENT ONLY, if the bill is PAID IN FULL with CASH OR CHECK ON THE DAY OF TREATMENT.

- As a courtesy, we will be happy to split your treatment fee for surgical procedures into three (3) equal payments to be charged to the credit card of your choice. The first payment will be charged the day of treatment, the second payment will be charged one month after treatment and the third and final payment will be charged two months after treatment.

- Payments for initial visits, periodontal recall/maintenance cleanings and x-rays are due at the time of service. We will provide you with the necessary documents for YOU to submit to your insurance. It is your responsibility to monitor the status of your claim. For all other procedures, a payment of 1/3 of the fee will be due at the time of service and we will submit the bill to your insurance. Any balance NOT COVERED by insurance is due within 90 days.

- Unless prior arrangements are made with our office, payment IN FULL, is due within 90 days whether or not you have insurance.

Please feel free to contact our office with any questions you may have.