IMPORTANT

Please READ

Financial Agreement

Northwest Family Dental

Financial Policy for Our Patients

Insurance:

We accept most traditional PPO dental insurance. *We do NOT participate in any DMO/HMO dental plans or reduced fee schedule plans.*

Our office understands the value of dental insurance and will file dental claims on your behalf. We will complete and process insurance claims forms for you as a courteous. You however will be responsible for the insurance portion if insurance chooses to deny a claim.

Most dental insurance plans ***do not*** cover 100% of the cost of treatment. Because of this, and a delay in receiving payment from the insurance company, you will be asked to pay your deductible as well as your estimated portion of your charges the day services are rendered.

We will ***estimate*** as closely as possible your coverage, but until we formally receive payment from your insurance carrier, it is just that ***- an estimate***. ***If we do not receive payment from your carrier within 30 days, the entire balance is due from you. If payment is not recieved a claims may be sent to COLLECTIONS.***

Please understand that we file your insurance benefits as a courtesy to you. If your insurance denies coverage or does not pay *for any reason*, you are ultimately responsible for any and all charges incurred in our office. It is your responsibility to keep up with you annual maximum coverage of dental benefits. This information is easily obtainable from your dental carrier.

Payment options:

Our office accepts cash, personal checks and all major credit cards for services. We do not finance any dental work ourselves.

******* Please be advised that we do charge a fee of between $40 and $90 for all failed and cancelled appointments *without 24 hours notice* *******

Signature_____ Date_____

NORTHWEST FAMILY DENTAL
6708 Azle Ave Suite 100,
Fort Worth, Texas 76135
817-237-3232

Patient Information

Date:_____/_____/_____
First Name:_____Last Name:_____Middle Initial:_____
Address:_____CIty:_____ State/Zip_____
Home Phone:(_____)_____-_____ Cell Phone: (_____)_____-_____
Sex : ☐ Male ☐ Female Marital Status:: ☐ Married ☐ single ☐ Divorced ☐ Separated ☐ widowed
Birth Date:_____ /_____/_____
Email:_____
Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Closest Relative or Friend:_____ Phone:_____
Primary Physician:_____Phone:_____
Dentist:_____ Phone:_____

Medical History

Are you under a physician's Care now?	☐ Yes ☐ No	Immune Compromised?	☐ Yes ☐ No
Do you use controlled substances?	☐ Yes ☐ No	Have ever had head/neck injury?	☐ Yes ☐ No
Do you or have you taken Phen-Fen or Redux?	☐ Yes ☐ No	Are you on a special Diet?	☐ Yes ☐ No

Do you have or have you had any of the following? Answer Yes or NO, please ***DO Not*** leave BLank:

AIDS / HIV	☐ Yes ☐ No	Depression / Bipolar	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Allergy / Hay fever	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Low Blood Sugar	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy / Seizures	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Nervousness / Anxiety	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Fainting/ Dizziness	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Head/ Neck/Back Pain	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cold Sore / Fever Blister	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	HPV	☐ Yes ☐ No	Bacterial Endocarditis	☐ Yes ☐ No

Women Only: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Are You Nursing ? ☐ Yes ☐ No

Please describe any serious illness, injury, hospitalization, or surgeries:

_____

_____

_____

_____

MEDICATION QUESTIONNAIRE

Please list all medications that you take, including PRESCRIPTION, HERBAL, and OVER THE COUNTER.

Medication	Reason Taking	Office Use Only

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Latex ☐Local Anesthetics ☐Other:

If yes,what kind of reaction? _____

DENTAL QUESTIONNAIRE

Smoke or use smokeless tobacco	☐Yes ☐No	Brush at least once a day	☐Yes ☐No
Bite/chew lips or cheeks	☐Yes ☐No	Use fluoride toothpaste	☐Yes ☐No
Have dentures that fit poorly	☐Yes ☐No	Floss at least once each day	☐Yes ☐No
Have a history of oral cancer	☐Yes ☐No	Drink tap water that has fluoride	☐Yes ☐No
Have frequent dry mouth	☐Yes ☐No	Drink bottled water only	☐Yes ☐No
Clench or grind teeth	☐Yes ☐No	Have regular dental visits	☐Yes ☐No
Need to improve nutrient/vitamin intake	☐Yes ☐No	Have dental implants	☐Yes ☐No
Have a family history of gum disease	☐Yes ☐No	Have chronic TMJ (jaw) problems	☐Yes ☐No
Gums bleed when brushing or flossing	☐Yes ☐No	Have oral piercing(s)	☐Yes ☐No
Have more than 2 alcoholic drinks per day	☐Yes ☐No	Are you nervous about having dental treatment?	☐Yes ☐No
Use alcohol based mouth rinse (Listerine/Scope)	☐Yes ☐No	Have you had a bad experience in the dental office?	☐Yes ☐No
Are you having any oral pain or dental discomfort at this time?	☐Yes ☐No		

When you play contact sports, do you use a mouth guard? ☐Yes ☐No ☐Not applicable

When did you last have a dental exam?_____Dental work_____Teeth cleaned_____

What type of toothbrush do you use? Soft_____Medium_____Hard_____

What toothpaste do you use?_____ What other hygiene aids do you use?_____

What is the main reason for your visit today?_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. *It is my responsibility to inform Northwest Family Dental of any changes in my medical status*. If the patient is under 18 years of age we ask that the parent/guardian stay at the dental office while treatment is rendered. *Parent/guardian must sign for patients under the age of 18.*

Date	Patient/Guardian Signature	FD	RDA	RDH	DDS

Patient Record of Disclosures

In General, the HIPAA Privacy Rule gives the patient the right to request on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner: (check all that apply)

☐ Home Telephone
☐ O.K. to leave message with detailed information
☐ Leave name/doctor with call back number only
☐ Work phone _____
☐ Leave detailed message on work voicemail
☐ Leave detailed message with name/doctor and call back number only
☐ When unable to contact me by phone, a written communication may be sent to my home address
☐ Other_____

_____

Patient signature Date

_____

Print name Birthdate