Northpointe Family Dentistry
605 E. Holland Avenue #108
Spokane WA 99218

www.northpointefamilydentistry.com

(509)465-5001

npfrontdesk@northpointefamilydentistry.com

Chart #. ____
FOR OFFICE USE ONLY

Patient Name:* ____ (Last) * ____ (First) ____ (MI) ____ (Preferred Name)

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

Birth Date:* ____ SS #. ____ Prev. Visit: ____

Email Address: ____ Best time to call: ____

Phone: * ____ (Home) ____ (Work) ____ (Ext) ____ (Mobile) ____ (Fax) ____ (Other)

Address:* ____ ____

* ____ (City) * ____ (State) * ____ (Zip Code)

Primary and Secondary Dental Insurance

Name of Insured: ____ (Last) ____ (First) ____ (MI)

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

Insurance Plan Name: ____

Name of Insured: ____ (Last) ____ (First) ____ (MI)

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

Insurance Plan Name: ____

Previous Dentist(s): Date of Last Exam:

Please call previous DDS and have current x-rays sent to LLFD prior to 1st appointment.

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Medical Insurance

Name of Insured: ______ Last ______ First ______ MI

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

Insurance Plan Name: ______

Group Plan, Group #, Employer

______

Medical Doctor Name: Phone:

______

Patient Medical History

- ☐ **See Notes**
- ☐ Allergies
- ☐ Allergy to Metals
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asprin Allergy
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bone Density Meds/IV
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Convulsions
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Latex Allergies
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolaps
- ☐ Nervous Disorders
- ☐ NO Ibuprofen/NSAID's
- ☐ Other
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pregnancy
- ☐ Pre-Medication
- ☐ Prv. Oral Pathology
- ☐ Radiation Treatment
- ☐ Respiratory Problems

- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Sulfa Allergy
- [ ] Thyroid therapy
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Other Medical Conditions:

List Allergies and type of reaction: (ie. hives, anaphylaxis, vomiting)

Medical Conditions and Doctor Treating: (ie. Kidneys- Dr. Smith)

List Medications w/ Dosages: (include vitamins and supplements, OTC pain meds.)

Dental History

Dental Pain or Problems: (areas or concerns to discuss with dentist)

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CONSENT FOR SERVICES

I certify that I have provided and reviewed the above medical information to the best of my knowledge; the answers are complete and accurate. I understand that information withheld may be dangerous to my health, and compromise recommended treatment. I, the undersigned patient,hereby give my consent for dental services to Dr. Michelle Olmstead or her qualified associates at LLFD.

◯ Yes ◯ No

INTERNET CONSENT

I understand LLFD presents claims to insurance companies by the internet, reminder appointments and correspondence. I have provided the e-mail address that can be used. I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password.

◯ Yes ◯ No

PAYMENT POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. I authorize and request my insurance company to pay directly to LLFD otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree to pay a $35 cancellation/re-schedule charge if 24-hours notice is not given.

◯ Yes ◯ No

NOTICE OF PRIVACY PRACTICES---ACKNOWLEDGEMENT

You may refuse to select yes to this portion.

We keep record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We do not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get information about it by contacting our Privacy Officer, Roxie Couch.

◯ Yes ◯ No

List family members that privacy policy excludes. (ie. Spouse-Jim)

Signature: ______________________

Date:

Response Date: