NORTH POINT DENTISTRY

KEVIN J. ORTALE, D.D.S., P.L.C.

REGISTRATION & MEDICAL HISTORY

Date _____

Date of Birth: _____
Month Day Year

PATIENT INFORMATION

Patient: _____ ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Child
Last First M.I.

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Ext. _____

Cellular # _____ Email Address: _____

Insurance Co.: _____ SS #: _____

Employer: _____ Driver's License #: _____

Address: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

Referred By: _____ Interest/Hobby: _____

MEDICAL HISTORY

Have you ever had any of the following? (check yes or no)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Heart Attack	☐	☐	Hepatitis A/B/C	☐	☐	Arthritis/Lupus
☐	☐	Mitral Valve Prolapse	☐	☐	Diabetes	☐	☐	Blood Disease	☐	☐	Sinus Problems
☐	☐	Rheumatic Fever	☐	☐	Respiratory Disease	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Pace Maker	☐	☐	Asthma/Emphysema	☐	☐	Liver Disease	☐	☐	Drug Addiction
☐	☐	Artificial Heart Valve or Joints	☐	☐	Epilepsy	☐	☐	Hemophilia			Alcohol, Narcotics, Prescription Drugs
☐	☐	High Blood Pressure	☐	☐	Allergic to Anesthetic	☐	☐	HIV Positive	☐	☐	Pregnant (current)
☐	☐	Low Blood Pressure	☐	☐	Allergic to Medicine or Drugs	☐	☐	A.I.D.S	☐	☐	Birth Control Pills (current)
☐	☐	Stroke	☐	☐	Tuberculosis	☐	☐	Venereal Disease	☐	☐	Smoke
						☐	☐	Cancer			

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

Physicians Name _____ Phone # _____ Date of last visit _____

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

If so, what? _____

Are you presently taking any medications / vitamins? ☐ Yes ☐ No

If yes, please list? _____

If child, weight: _____

Do you have any medical condition not listed above? ☐ Yes ☐ No

If yes, please list: _____

The reason you left the previous dentist: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ *Signature* _____ ***OVER***

ASSIGNMENT & RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

GOAL

OUR GOAL IS TO SERVE YOU WITH QUALITY AND GENTLE CARE.
WE ARE HERE TO MEET YOUR DENTAL NEEDS IN A COMFORTABLE AND PROFESSIONAL ATMOSPHERE.

APPOINTMENT

OUR TIME IS AS VALUABLE AS YOURS, PLEASE GIVE US A 24 HOURS CANCELLATION NOTICE SO WE CAN BE AVAILABLE TO THE OTHER PATIENTS.

FINANCE

ALL FEES ARE DUE WHEN THE SERVICES ARE RENDERED. WE APPRECIATE YOUR PROMPT RESPONSE.

REFERRAL

OUR PRACTICE CONTINUES TO GROW BY YOUR CONFIDENCE IN US AND YOUR REFERRAL. THANK YOU.

NORTH POINT DENTISTRY

KEVIN J. ORTALE, D.D.S., P.L.C.

PREOPERATIVE CONSENT

Patient Name _____

1 ORAL SURGERY & ENDODONTIC SURGERY

Possible Risks Involved:

Pain, bleeding, swelling, infection, sinus involvement, TMJ symptoms, retained root tops, jaw fracture. Nerve damage which may include temporary or permanent numbness of lip, chin, or tongue, and damage to adjacent teeth, including restoration.

2 ENDODONTIC THERAPY (ROOT CANAL FILLINGS)

Explanation:

Endodontic therapy is an attempt to save a tooth which might otherwise be lost. Following endodontic therapy it is usually necessary to do a post/core and crown to avoid tooth fracture. Your options are either to try to save the tooth with endodontic therapy or to have the tooth extracted.

Risks:

Treatment is not always successful. Occasionally, a tooth may require re-treatment, surgery or extraction. There are some risks such as, but not limited to: file separation, perforation, hypercalcification, tooth fracture, under/overfill, infection and possible loss of the tooth.

3 FIXED PROSTHODONTICS (CROWN & BRIDGE)

When we diagnose the need for a crown or bridge it is usually because the tooth can not be restored with a conventional restoration due to a pre-existing large or broken filling, a fractured cusp, deep carious lesion or the tooth has been endodontically treated. Be aware that when preparing a tooth for a crown or bridge, we need to reduce a certain amount of tooth structure, increasing the probability for the tooth to become sensitive or to require endodontic treatment (Root Canal Therapy). In case of the need for a RCT after a crown has been placed, we may need to access the pulp (nerve tissue) through the crown, or replace the existing crown with a new one.

4 ANESTHETICS, ANALGESIA, SEDATIVES

I agree to the use of any necessary or advisable local anesthetics, analgesia, conscious sedation, nitrous oxide-oxygen analgesia, and any sedative drugs necessary to control pain, apprehension.

_____

I fully understand this authorization, and I have been given the opportunity to ask questions, which have been answered to my complete satisfaction. I understand the risks, benefits and alternatives and consent to these procedures.

_____ _____

Signature of Patient/Guardian *Signature of Attending Dentist*

_____ _____

Date

Kevin Ortale, DDS, PLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: KEVIN ORTALE

Telephone: 602-404-0330 Fax: 602-404-0312

E-mail: DRORTALE@GMAIL.COM

Address: 702 E. Bell Road, #114, Phoenix, Arizona, 85022

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

NORTH POINT DENTISTRY
Dentistry for the Entire Family

PHONE: (602) 404-0330 KEVIN J. ORTALE, DDS, PLC FAX: (602) 404-0312

702 E. BELL ROAD, SUITE #114 • PHOENIX, AZ 85022
Committed to excellence in providing high quality oral health care for your family!

FINANCIAL POLICY

To accommodate the needs and request of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is very difficult for us to keep track of all of the individual requirements of the plans. Each plan has different restrictions reqarding which services are covered and how often services may be rendered.

Even within a single insurance company, the plans differ, depending on what type of contract your employer had negotiated. Providing the **highest quality** of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan quidelines, whenever possible.

Unfortunately, if you do not inform us of special requirements required by your insurnace plan and we order services that you need and agree to which are not covered by your insurance plan, we may bill you directly for those charges. Payment for these services may be your responsibility.

With your cooperation and our help, you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on your dental needs.

With this in mind, please read the following and sign below:

I hereby give permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered.

I authorize the release of any medical information necessary to process my claim to my insurnce company. I furthermore authorize payment of all insurance benefits, if any, directly to Kevin J. Ortale, D.D.S. for services rendered. I guarantee that the information I have given is correct and understand that I am responsible for financial loss due to inaccurate information provided by me.

In the event that payment is not made on this account and it is placed with our licensed collection agency, I agree to pay the fees of the collection agency equal to the maximum of 50% of my outstanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action also be necessary to collect the account, I agree to pay attorney's fees and court costs incurred for collection.

I further understand that should any check submitted to this office for payment that is returned for any reason by the bank from which the check was drawn, there will be a $25.00 returned check charge for which I am responsible. **If I am unable to make an appointment, I must contact the office at least 24 hours in addvance to avoid a $25.00 charge.**

I HAVE READ AND UNDERSTAND TH OFFICE FINANCIAL POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient Signature Date