Northwell Health
Dental Medicine

REGISTRATION FORM

Patient Information

Patient Name	Gender	DOB	Ethnicity: Other: ☐ Hispanic Origin: ☐ Non-Hispanic Origin: ☐ Declined: ☐
Preferred Name		Parent 1 Name:	Parent 2 Name:
Preferred Language	Race: African American/Black ☐ Native American/Alaskan ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to Answer ☐ Other _____		
Marital Status: Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Married ☐ Civil Union ☐ Name of Spouse: _____			Northwell Employee Yes ☐ No ☐
Address		City, State, Zip	

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email Address: _____
Email Belongs To: _____

Please Select Your Preferred Appointment Reminder Method:
Home Phone ☐ Cell Phone ☐ No Reminder ☐

No Email ☐
Declined ☐

How did you hear about us?
Northwell employee communications ☐ Northwell Website ☐ Social media platforms, eg. Facebook, Twitter and others ☐
Private practice office referrals ☐ Referred by friends/family ☐ Referred by other Northwell office Other

Sexual Orientation & Gender Identity

Gender Identity:
Female ☐ Male ☐
Non Binary/GNC/Gender Queer ☐
Transfemale/Male to Female ☐
Transmale/Female to Male ☐
Withheld/Decline to answer ☐

Birth Sex:
Female ☐ Male ☐
Other/Intersex ☐

Preferred Pronoun:
He/She ☐ Them/They ☐
Withheld/Decline to answer ☐ Various/Other ☐
Name you prefer to identify with: _____

Pharmacy Information

Pharmacy Name and Location: Pharmacy Phone:

Contact Information

Contact Name	Relationship	Contact Type Emergency	Preferred Phone Preferred Phone	Alternate Phone

Guarantor Information

Guarantor Name	Guarantor DOB	Relationship to Patient
Guarantor Phone	Guarantor Address	City, State, Zip

Physician Information

Referring Physician Name: Referring Physician Phone:

Primary Care Physician Name: Primary Care Physician Phone:

Insurance Information

Primary Dental Insurance Name:	Subscriber Name:	DOB:	Relationship:
Primary Dental Insurance Address:		Phone:	Group/ID Number:
Secondary Dental Insurance Name	Subscriber Name:	DOB:	Relationship:
Secondary Dental Insurance Address:		Phone:	Group/ID Number:
Primary Medical Insurance Name:	Subscriber Name:	DOB:	Relationship:
Primary Medical Insurance Address:		Phone:	Group/ID Number:
Secondary Medical Insurance Name:	Subscriber Name:	DOB:	Relationship:
Secondary Medical Insurance Address:		Phone:	Group/ID Number:

Northwell Health
Dental Medicine

Medical History

Patient Name_____Patient's DOB _____

Patient Address_____Patient's Telephone # _____

Referring Physician's Name, Address & Phone _____

Reason For Today's Visit _____

Are you in good health? Yes ☐ No ☐ If no, Explain_____

Date of Last Medical Exam _____ Physician's Name _____Telephone #_____

Date of Last Dental Exam _____ Dentist's Name _____Telephone #_____

Do you have or have you had any of the following diseases or problems (Please Check)

- ☐ Alcohol use/abuse
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Asthma/Hay fever
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart disease
- ☐ COPD/Emphysema
- ☐ Cortisone or steroid treatment
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Developmental Disability
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart attack
- ☐ Heart Disease
- ☐ Heart Murmur/damaged valves
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS/immunosuppression
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous problems/psychiatric care
- ☐ Pacemaker/Defibrilator
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of breath on exertion
- ☐ Skin rash/hives
- ☐ Sickle Cell Trait/Disease
- ☐ Smoke/tobacco use
- ☐ Stroke
- ☐ Swollen ankles
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Other health problems:

Are there significant family medical problems? _____

Do you have any allergies: Yes ☐ No ☐ If yes, what? _____
Are you allergic to metal? Yes ☐ No ☐ Are you allergic to latex? Yes ☐ No ☐
Do you smoke? Yes ☐ No ☐ How much?_____. How long?_____

History of hospitalizations/surgery _____
Female patients: Are you pregnant? Yes ☐ No ☐ Are you taking birth control pills? Yes ☐ No ☐
****PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING****:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Northwell Health
Dental Medicine

Dental History

Patient Name:_____ Date of Birth: _____

		Yes	No
1.	Have you ever been to the dentist before?	☐	☐
2.	When did you last see a dentist? _____		
3.	For what reason? _____		
4.	Have you ever had a complete series of x-rays taken of your teeth?	☐	☐
5.	Do you have frequent headaches?	☐	☐
	When was last headache? _____		
6.	How many times a day do you brush your teeth? _____		
7.	Has anyone (dentist, hygienist, nurse, or physician) ever shown you how to clean your teeth?	☐	☐
8.	Do you use dental floss regularly?	☐	☐
9.	Have you ever had treatment for your gums?	☐	☐
10.	Do you like the way your teeth look?	☐	☐
11.	Do your gums bleed or hurt when you brush them?	☐	☐
12.	Do you feel you have bad breath?	☐	☐
13.	Do your teeth feel loose?	☐	☐
14.	Are your teeth sensitive to heat, cold, or sweets?	☐	☐
15.	Do any teeth hurt when you chew?	☐	☐
16.	Do you clamp, clench, or grind your teeth during the day or night?	☐	☐
17.	Have you been aware of any swelling in the face or neck?	☐	☐
18.	Do you have any trouble with your speech?	☐	☐
19.	Do you have other serious or disabling tooth, gum, or jaw problems?	☐	☐
20.	Do you have sinus problems?	☐	☐
21.	Have you had any head, neck, or jaw injuries?	☐	☐
22.	Have you had prolonged bleeding following extractions?	☐	☐
23.	Have you ever had orthodontic treatment?	☐	☐
24.	Do you have dentures, partials, or implants? If yes, when_____	☐	☐
25.	Have you had an oral ulcer or canker sores? If yes, how often_____	☐	☐
26.	Do you have dry mouth or burning mouth?	☐	☐
27.	Do you have taste disorder?	☐	☐
	For parents: Does your child suck his/her thumb?	☐	☐
	Does your child go to sleep with a bottle in his/her mouth or do you use the bottle as a pacifier?	☐	☐
	Does your child take fluoride supplements?	☐	☐

Please read and sign the following:

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____
Signature of Patient or Guardian Date

History reviewed by doctor: _____ _____ _____
Signature Beeper Date

_____
Print Name

Update of Medical History

Date	New Findings	None	Reviewed by:	Beeper #
_____	_____	☐	_____	_____
_____	_____	☐	_____	_____
_____	_____	☐	_____	_____

Circle One: ASA I II III IV

Northwell Health®
Dental Medicine

Consent to Treatment, Assignment of Benefits, and Guarantee of Payment

Consent to Treat

I authorize the dental medicine staff at Northwell Health Dental Medicine to provide care and to administer such diagnostic, radiological and/or therapeutic procedures and treatments as the dental medicine staff determines is necessary or advisable in my care. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient, and I will indicate my relationship to the patient where indicated below. For a list of Northwell Health Dental Medicine locations, please visit https://www.northwell.edu/doctors-and-care/locations?keywords=dental&zip-&type=.

Assignment of Benefits

I hereby irrevocably assign and transfer to Northwell Health Dental Medicine any monies or benefits to which I may be entitled, including benefits/monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my dental care. I authorize and direct Northwell Health Dental Medicine, having treated me, to release to such payers or other third parties who are financially responsible for my dental care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my dental care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also appoint Northwell Health Dental Medicine as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials and proceed against my insurance company in any action including legal suit, on my behalf if for any reason my insurance company refuses to pay my claim. The appointment shall include all rights to recover attorney's fees and costs for such action brought by Northwell Health Dental Medicine as my assignee. I further agree to provide information as necessary and to cooperate with Northwell Health Dental Medicine to process and obtain payments.

Patients Entitled to Medical Benefits

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release it to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers for the purpose of payment. I request that payment of authorized benefits related to my care be assigned to Northwell Health Dental Medicine.

Guarantee of Payment

I understand that I am financially responsible for charges not covered by insurance. I agree to pay all amounts for which I am responsible for services rendered in accordance with the rates and terms of Northwell Health dental Medicine or as determined by my health plan. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses.

Patient/Agent/Relative/Guardian (Signature)	Date/Time	Print Name	Relationship other than patient

Telephonic Interpreter's ID #	Date/Time

Signature: Interpreter	Date/Time	Print: Interpreter's Name and Relationship to Patient

Northwell Health
Dental Medicine

OUTPATIENT CONTACT CONSENT FORM

Email, Text Messages, and Voicemail

It is important for Northwell Health to be able to communicate with you about your healthcare. By providing an email address or phone number, you agree that Northwell Health, its contractors and their subcontractors may use those means of communication, including autodialed phone calls*, autodialed text messages, and voicemails, for the purposes of communicating about your health care, including appointment related information, providing portal invitations, health reminders, identity authentication, prescription information, test results, and information about billing and payment for the medical and dental services you receive. Message and data rates may apply to text messages, and not all carriers are covered. You can always text STOP to stop (a confirmation message will be sent) or HELP for help.

Messages sent through email or SMS text will be limited in the information they contain to protect your privacy. These text messages and emails are not encrypted in transit and may be accessed by others not affiliated with Northwell Health while in transit or upon receipt. To reduce the chance that your information is seen by the wrong recipient, we suggest you enable the highest security measures on your personal devices (passcodes, strong passwords, two step authentication, etc.)

Method of communication:

If you DO NOT want Northwell to communicate with you via the email or phone number you provided, please initial below. **Please note:** If you opt out of communication below, you may still receive information necessary to access or prepare for in-person or virtual appointments (such as links to health visits), as well as specific communications you request.

☐ DO NOT email me ☐ DO NOT text me

☐ DO NOT leave a voice mail message for me

It is important for you to keep contact information with Northwell Health up to date and review your emails and phone numbers at each visit. If you have previously opted our of e-mail, text messages, and/or voicemails and express a change in your preferences on this form at this visit, you have opted back into all future email, text and/or voicemail communications.

*This includes autodialed phone calls to landlines and cell phones.

_____ _____

Patient Name Patient DOB

VD145430 (02/12/2022)

Northwell Health
Dental Medicine

OUTPATIENT CONTACT CONSENT FORM

My Care Contacts

Check here if you do not wish for us to speak with anyone but you.

If you would like to authorize Northwell Health to communicate with other individuals about your healthcare, please indicate your communication preferences below. The care contacts below are not applicable in NYS Office of Mental Health (OMH) – licensed programs. I give Northwell Health consent to communicate with the following individual(s) about my healthcare (such as appointment details, prescription information, text results, billing and payment).

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

_____ _____

Patient Name Patient DOB

VD145430 (02/17/2022)

Northwell Health
Dental Medicine

OUTPATIENT CONTACT CONSENT FORM

Acknowledgement

By signing below, I understand that Northwell Health has my permission to contact me or my Care Contact(s) identified on this form in the manner described herein. I understand that I am responsible for notifying the office staff if there are changes to my designated communication preferences. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient where specified below.

Patient/Agent/Relative/Guardian* Signature	Date	Time	Print Name	Relationship if Other than Patient
Telephonic Interpreter's ID # OR	Date	Time		
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Patient Name	Patient DOB

Northwell Health
Dental Medicine

Acknowledgement Of Receipt

I have received a copy of the Provider's Notice of Privacy Practices

_____	_____	_____	_____	
Patient/Agent/Relative/Guardian* Signature	Date	Time	Print Name	Relationship if Other than Patient

_____	_____	_____
Telephonic Interpreter's ID #	Date	Time

_____	_____	_____	_____
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient

_____	_____	_____	_____
Witness to signature (Signature)	Date	Time	Print Witness Name

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PROVIDER USE ONLY

_____ Patient or representative refused to sign/accept Notice of Privacy Practices

_____ Patient unable to sign

_____	_____	_____
Telephonic Interpreter's ID #	Date	Time

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.