Portland North Dental Associates
Robert A. DeRice DMD
Christopher D. Pochebit DMD
9 Sanborn Street
Portland, ME 04103
207-878-3100
info@portlandnorthdental.com

WELCOME

Thank you for contacting our office. We welcome you into our practice and look forward to caring for your dental needs. We hope that you will be pleased with our efforts on your behalf and with the consideration and friendliness of our staff.

In our preventive oriented practice we attempt to correct your dental problems before they become complicated and make sure that you know what you can do at home to prevent tooth decay and gum disease. Proper treatment, good home care and periodic examinations can maintain the health of your mouth for a lifetime.

After our examination we will recommend a course of treatment. Alternative procedures sometimes need to be discussed before choosing the best course of treatment. Please feel free to ask us about anything you do not understand.

APPOINTMENTS & CANCELLATIONS

All visits are by appointment. We ask that you please be prompt and not miss your reserved time. If you must cancel, we require a minimum of one full business day's notice. This will allow us time to give someone else the opportunity to schedule their dental needs.

Any cancellation, which is not given a full day's notice, will be charged 50% of the fee for the scheduled procedure. Also, if we are late by 10 minutes or more in bringing you into the operatory for treatment, the fee for the procedure will be reduced by $1.00 for each minute we are late. This does not, however, apply to emergency visits.

PAYMENT INFORMATION

PAYMENT FOR ALL SERVICES WILL BE MADE AT THE END OF EACH VISIT.
Cash, checks, debit and credit cards are all accepted. Treatment requiring laboratory work, such as lab Crowns, Bridges, Dentures, Appliances, etc. **will require a deposit of one-half the fee before treatment and the balance is due upon completion.** Cerec crowns are an exception, as they are completed in office in a single day and will need to be paid in full that day. If you have dental insurance, your co-payment (percentage your insurance does not pay) will be required WHEN SERVICES ARE RENDERED! Our office generates insurance forms and will be happy to process the original claim form for you. Please remember, however, the policy is between you and the insurance company and after a period of SIX WEEKS, if the claim has not been paid, the balance becomes your responsibility. Regardless of what insurance does/doesn't pay **you are ultimately responsible** for the balance. Also, as we have a number of insurance plans in our computer system, it is impossible to know all of the details of every plan and it is your responsibility to be aware of the particulars.

Once again, welcome to our practice and thank you for taking the time to complete the attached general information and health forms.

I HAVE READ AND UNDERSTAND THE ABOVE:

Patient's Name (printed): _____

Date: _____

Signature of Patient: _____
(Signature of Parent/Guardian if a Minor:)

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General Information

PATIENT INFORMATION

Patient's Last Name, First Middle	Title (circle one) Mr. Mrs. Miss Ms. Dr.	Marital Status (circle one) Single Mar Div Sep Wid

**** Please circle your preferred method of contact (home phone, work phone, cell phone or email) ****

Home Phone No.	Work Phone No. (Include Ext.)	Cellular No.
( )	( )	( )

Email Address

Street Address City State Zip Code	Social Security No.	Date Of Birth

Mailing Address (if different than above) City State Zip Code	Sex (circle one) M F	Age

Whom May We Thank For Referring You To Us?	Employer OR (If College Student) School Name	Name & Phone No. Of Nearest Relative Or Emergency Contact
		( )

FINANCIAL INFORMATION

Name Of Person Responsible For The Account	Relationship	Spouse's Name

Address (if different than above) City State Zip Code	Social Security No.	Date Of Birth

Is This Person A Patient In Our Office? (circle one) Yes No	Home Phone No.	Work Phone No. (Include Ext.)
	( )	( )

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Insurance Information

Patient's Last Name, First Middle	Date Of Birth

PRIMARY DENTAL INSURANCE INFORMATION

Primary Insured/Subscriber's Full Name	Relationship To Patient	Social Security No.	Date Of Birth

Employer Name	Work Phone No. (Include Ext.) ( )	Address Of Employer

Insurance Company Name	Insurance Company Address City State Zip Code

Insurance Company Phone No. ( )	Subscriber ID No.	Employer Group No.	Annual Deductible Amount

SECONDARY DENTAL INSURANCE INFORMATION (if applicable)

Secondary Insured/Subscriber's Full Name	Relationship To Patient	Social Security No.	Date Of Birth

Employer Name	Work Phone No. (Include Ext.) ( )	Address Of Employer

Insurance Company Name	Insurance Company Address City State Zip Code

Insurance Company Phone No. ( )	Subscriber ID No.	Employer Group No.	Annual Deductible Amount

MEDICAL INSURANCE INFORMATION

Primary Insured/Subscriber's Full Name	Relationship To Patient	Social Security No.	Date Of Birth

Employer Name	Work Phone No. (Include Ext.) ( )	Address Of Employer

Insurance Company Name	Insurance Company Address City State Zip Code

Insurance Company Phone No. ( )	Subscriber ID No.	Employer Group No.	Annual Deductible Amount

I authorize Portland North Dental Associates to bill my dental claims to my insurance company on my behalf and authorize any applicable payments directly to their office.

_____ _____

SIGNATURE OF PATIENT (PARENT IF A MINOR) *DATE*

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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

MEDICAL HEALTH INFORMATION

Patient's Last Name, First Middle	**Name And City Of Physician:**	**Preferred Pharmacy And Town:**
Patient's DOB:	**Month/Year of Last Physical:**	

***** Please Check Each Box Below If The Answer Is OR Has Ever Been: "YES" (Leave Blank If "NO") *****

HEART PROBLEMS	OSTEOPOROSIS *****IF "YES",***	CHRONIC SINUS
HIGH BLOOD PRESSURE	***Are You Taking Bone Density***	CHRONIC EAR PROBLEMS
LOW BLOOD PRESSURE	***Medications?*** (List Below)	ARTHRITIS
CIRCULATORY PROBLEMS	JOINT REPLACEMENT	RHEUMATIC FEVER
DIABETES	ORGAN TRANSPLANT	EPILEPSY
HEPATITIS	EXCESSIVE BLEEDING	SCARLET FEVER
ASTHMA	ANEMIA	CEREBRAL PALSY
RADIATION TREATMENTS	TUBERCULOSIS	HPV 16/18
MALIGNANCIES	NERVOUS PROBLEMS	HIV POSITIVE (OPTIONAL)
STROKE	KIDNEY PROBLEMS	VENEREAL DISEASE

Do You Use Tobacco Products? Smoke: NO / YES - _____ Packs/day Chewing Tobacco: NO / YES

Are You Allergic To: (circle all that apply)
Penicillin Latex Local Anesthetic (Novocain, Etc) Other(s):

Have You Ever Been Advised To Take A Premedication (Antibiotic) Prior To Your Dental Visits? NO / YES
If Yes, Please Explain:

Please List All Medications You Currently Take (Include Over-The-Counter And Herbal Supplements):

Please List Any Other Medical Conditions/Health Complications That You Feel The Doctor Should Be Aware Of:

WOMEN ONLY: Have You Had The Gardisil Vaccine? NO / YES
Are You Pregnant? NO / YES (Due Date: _____) Nursing? NO / YES
Are You Taking Birth Control Pills? NO / YES Other Chemically Based Form Of Birth Control? NO / YES

DENTAL HEALTH INFORMATION

Name Of Previous Dentist	**Address City State Zip**	**Phone No.** ( )

Date Of Last Visit	**When Were Your Last Dental X-Rays?**

Are Your Teeth Sensitive To: (circle all that apply) Heat Cold Sweets Chewing

Have You Had Any Injuries To The Mouth Or Jaw? NO / YES If Yes, Please Explain:

Please List Any Previous Dental Experience Or Current Dental Concerns You Would Like The Doctor To Be Aware Of:

Have You Ever Been Treated For: (circle all that apply) Orthodontics TMJ Disorder
If Yes, Please Explain: Periodontal Disease Oral Surgery

If Patient Is A Child, Is This Their First Dental Visit? NO / YES
Does Your Child Ever Complain Of Any Teeth Hurting? NO / YES
Do You Notice If Your Child Is A: (circle any that apply) Thumb Sucker Tongue Thruster

_____ _____

SIGNATURE OF PATIENT (PARENT IF A MINOR) *DATE*

Portland North Dental Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse To Sign This Acknowledgement **

I, _____, have been offered and/or received a copy of Portland North Dental Associate's Notice of Privacy Practices.

As parent and personal representative for my minor child/children, I acknowledge receipt of the notice of privacy practices for (please **print** full names of all applicable children):

_____ Child's Name

_____ Child's Name

_____ Child's Name

_____ Child's Name

_____ **Signature** Of Patient and/or Guardian of Above

_____ **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____