NORTH HILLS PERIODONTICS, LLC

Charu S. Chandra, D.M.D., M.D.S.
222 South Clay Street, Zelienople, PA 16063 • 220 N. Main Street, Suite 1, Butler, PA 16001
724-453-0234 • infor@northhillsperio.com

REGISTRATION AND TREATMENT FORM

Name ____
Last First Middle Initial

Address ____
Street City State Zip Code

Home Phone ( ) ____________________ Cell Phone ( ) ______________________________

Work Phone ( ) ______________________ May we call your work number? Y________ N ________

Employer____

Email ____Social Security # ________-_______-__________

Date of Birth ______/______/______ Single _____ Married ____ Widowed ____ Separated ____ Divorced____

Emergency Contact____________________________________ Phone ( )______________________

Name of Dentist____

DENTAL INSURANCE INFORMATION

Insured ____ Relationship to Insured ____________________

Social Security/ID # ______________________________________Date of Birth ______/______/_________

Insurance Company ____ Phone ( )__________________

Group # _______________________Employer ____

SECONDARY DENTAL INSURANCE

Insured ____ Relationship to Insured ____________________

Social Security/ID # ______________________________________ Date of Birth ______/______/_________

Insurance Company ____ Phone ( )__________________

Group # _________________________Employer ____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges and my balance regardless of insurance. I understand that I may incur a 12% APR if my account is not paid in full at time of service or payment plan is delinquent.

Signature ____ Date____________________

DENTAL HISTORY

Patient's Name: ________________________________ Phone (   )__________________

Name of Dentist: ____

Reason for today's visit____

Date of last dental visit _____/_____/________ Date of last dental x-rays _____/_____/________

Check (✓) if you have had problems with any of the following:

___ Bad breath	___Grinding teeth	___Sensitivity to hot
___ Bleeding gums	___ Loose Teeth	___ Sensitivity to sweets
___ Clicking or popping jaw	___ Periodontal treatment	___ Sensitivity when biting
___ Food collection between teeth	___ Sensitivity to cold	___ Sores or growths in mouth

How often do you brush? __________________How often do you floss? ___________________

Any other oral hygiene aids? Please list____

MEDICAL HISTORY

Physician's Name ______________________________ Date of last visit_____/_____/________

Have you had any serious illnesses or operations? ………………………………... Yes No

Have you ever had a blood transfusion? ……………………………………………... Yes No

If yes give approximate date____

Have you been hospitalized recently?……………………………………………… Yes No

If yes describe ____

(Women)

Are you pregnant?………………………………………………………………….. Yes No

Nursing?…………………………………………………………………………… Yes No

Taking birth control pills?..……………………………………………………... Yes No

Check (✓) if you have or have had any of the following:

___ Anemia	___ Cough, Persistent	___ Hepatitis *Type*____	___ Respiratory Disease
___ Arthritis, Rheumatism	___ Cough up Blood	___ High Blood Pressure	___Rheumatic Fever
___ Artificial Heart Valves	___ COVID-19 **Exposure/Positive**	___ HIV/AIDS	___Shortness of Breath
___ Artificial Joints	___ Diabetes	___Jaw Pain	___Stroke
___ Asthma	___ Epilepsy	___ Kidney Disease	___Swollen Feet/Ankles
___ Back Problems	___ Fainting	___ Liver Disease	___Thyroid Problems
___ Blood Disease	___ Glaucoma	___ Mitral Valve Prolapse	___ Tobacco Habit
___ Cancer	___ Headaches	___ Nervous Problems	___ Tonsillitis
___ Chemical Dependency	___ Heart Murmur	___Osteoporosis	___ Tuberculosis
___ Chemotherapy	___ Heart Problems	___ Pacemaker	___ Ulcer
___ Circulatory Problems	**Describe**______________	___ Psychiatric Care	___ Venereal Disease
___ Cortisone Treatments	___ Hemophilia	___ Radiation Treatment	

List medications you are currently taking (include vitamins, herbal supplements)

____

____

List allergies____

Signature____ Date ______________________________

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WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, check off the statements that apply to you.

Name: ______________________________	(Yes)	(No)
1. I am nervous being in a dental chair.	_____	_____
2. I have had a bad experience in a dental office.	_____	_____
3. I sometimes get dizzy lying back in a dental chair.	_____	_____
4. I have had difficulty with gagging or suctioning.	_____	_____
5. I would like to take breaks during long appointments.	_____	_____
6. My teeth or gums are very sensitive.	_____	_____
7. I don't like dental noises such as drilling or suctioning.	_____	_____
8. I haven't been to the dentist in a long time and am afraid of what you might say about my teeth.	_____	_____
9. I am not comfortable being lectured to by doctors.	_____	_____
10. I will need to relay what you tell me to spouse or someone else.	_____	_____
11. I don't like shots (or have had bad experience with them).	_____	_____
12. I have concerns about the appearance of my teeth or smile.	_____	_____
13. I have concerns about, eating, chewing, or bad breath.	_____	_____
14. I have concerns about insurance or finances.	_____	_____
15. I have another question or concern. (Please write it below.)	_____	_____

____

____

Thank you for sharing your thoughts.

Dr. Chandra & Staff

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FINANCIAL POLICY

Thank you for choosing North Hills Periodontics, LLC. Our primary mission is to deliver the best and most comprehensive periodontal care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS (you can choose from the following)**:**

- Pay-In-Full with a check and receive a 3% discount (applies to surgical procedures only)
- Pay-In-Full with cash and receive a 5% discount (applies to surgical procedures only)
- Visa, MasterCard, Discover, American Express
- Care Credit and Third Party Financing for larger amounts (zero interest and fixed rate plans available)
- In-House Payment Plan with *zero interest. Payment plan requires a credit or debit card. A monthly payment will be automatically charged to your credit or debit card on the 1st or 15th of every month. Payment plans are subject to approval. ***No interest if paid within the agreed term with no late, missed and/or declined payments. Otherwise, interest assessed from date of service. Minimum monthly payment required.***

North Hills Periodontics, LLC requires payment on the day of your treatment, unless alternative payment arrangements are made prior to procedures. We charge 12% interest on all past due accounts over 60 days (interest rate subject to change) and charge $25 for returned checks.

DENTAL INSURANCE PATIENTS:
For patients with dental insurance, we are out-of-network. As a courtesy, we bill your carrier and work hard to maximize your benefits. ***Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.*** All charges are your responsibility from the date services are rendered. If a claim is assigned to us and we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Insurance plans have become very complex. We will be glad to predetermine your benefits, but this can delay treatment by 2-6 weeks as we wait for the company to provide us with their estimate. Please let our staff know you would like a pre-determination.

CANCELLATION POLICY:
Appointments are reserved just for you. We reserve the right to charge for broken or missed appointments if we do not receive a 3 business day notice for office visits and hygiene appointments and a 5 business day notice for surgery appointments.

I have read and understand the above Financial Policy and my signature below authorizes North Hills Periodontics to bill my insurance carrier and to take payments over the phone.

Patient's Name:____

Patient's Signature (patient/guardian):____ Date:____________

We are here to help you get the treatment you need. We welcome any and all questions you may have regarding your care.

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NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explaining of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

1. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices

currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information by asking to speak to our Privacy Officer or for written inquiries note, "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand North Hills Periodontics, LLC's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that North Hills Periodontics, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact you at any time to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

In addition to insurance carriers and healthcare providers, I authorize release of my health information to the following:

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

Patient's Name: ____

Patient's Signature (parent/guardian): _________________________________Date: __________

FOR OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date: ___________ Initials: __________ Reason: ____________________________________

Periodontal Risk Assessment Questionnaire

Name ______________________________ Date ______________

Tobacco Use

Tobacco use is the most significant risk factor for gum disease.

Do you now or have you ever used the following:

	Amounts per day	*Used for how many years*	*If you quit, list what year*
❑ Cigarette	________	________	________
❑ Cigar	________	________	________
❑ Pipe	________	________	________
❑ Chewing	________	________	________

Blood Sugar

Diabetes

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? ❑ Yes ❑ No

Are you prone to diabetic complications? ❑ Yes ❑ No

How do you monitor your blood sugar? ______________________

Who is your physician for diabetes? ______________________

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? ❑ Yes ❑ No

Have you had any of these warning signs of diabetes?

❑ frequent urination ❑ excessive thirst

❑ excessive hunger ❑ weakness and fatigue

❑ slow healing of cuts ❑ unexplained weight loss

Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Do you have any risk factors for heart disease or stroke?

❑ Family history of heart disease ❑ Tobacco use ❑ Obesity

❑ High cholesterol ❑ High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Medications

A side effect of some medications can cause changes in your gums.

Are you taking or have you ever taken any of the following medication:

❑ Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)

❑ Yes ❑ No

If you answered yes, are you still taking the anti-seizure medication?

❑ Yes ❑ No

Other Medication: ______________________

❑ Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: ______________________

❑ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteriods (Asthma-Inhalers), etc.)

Other: ______________________

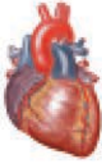
Family History/Genetics

The tendency for gum disease to develop can be inherited.

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

❑ Yes ❑ No

COLLAGENEX pharmaceuticals



Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

Do you have a heart murmur or artificial joint?

❑ Yes ❑ No

If so, does your physician recommend antibiotics prior to dental visits?

❑ Yes ❑ No

Name of physician? ______________________________

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Females

Females can be at increased risk for gum disease at different points in their lives.

The following can adversely affect your gums. Please check all that apply:

❑ Pregnant ❑ Nursing ❑ Menopause

❑ Taking birth control pills

❑ Infrequent care during previous pregnancies

Women

Women with osteoporosis have a greater risk for periodontal bone loss.

Females:

Do you take any of the following:

❑ Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Forteo®, etc.)

Other: ____

Stress

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress?

❑ Yes ❑ No

Nutrition

Your diet has the potential to affect your periodontal health.

Do you find it difficult to maintain a well-balanced diet?

❑ Yes ❑ No

All patients please complete the following:

Have you noticed any of the following signs of gum disease?

❑ Bleeding gums during toothbrushing
❑ Red, swollen or tender gums
❑ Gums that have pulled away from the teeth
❑ Persistent bad breath
❑ Pus between the teeth and gums
❑ Loose or separating teeth
❑ Change in the way your teeth fit together
❑ Food catching between teeth

Is it important to keep your teeth for as long as possible? ❑ Yes ❑ Not really

If you have missing teeth, why have you not had them replaced? ______________________________

____

Do you like the appearance of your smile? ❑ Yes ❑ No

Do you like the color of your teeth? ❑ Yes ❑ No

Do your teeth keep you from eating any specific food? ❑ Yes ❑ No