

Patient Name: \_\_\_\_\_ Patient Account No.: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Date of last Dental visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_ Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do you gums or bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No

Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

**Do you:**

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign object with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

**Have you ever had:**

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A biteplate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		

**Have you experienced:**

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing your mouth?	Yes	No
Difficulty in chewing on either side of your mouth?	Yes	No
Headaches, Neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

**Are you satisfied with your teeth's appearance?**

Would you like to keep all of your teeth all of your life?	Yes	No
Do you nervous about having a dental treatment?	Yes	No
If so what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe _____		

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No
If yes, describe _____		

(Please complete other side)

Patient Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

1. Physicians Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Have you had any medical care within the past two years? Yes No

Describe \_\_\_\_\_

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes No

4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No

If yes, did you take any of the following? (Circle if yes) Fen-Phen Pondimin Redux Other

If yes to any of the above, did you have a medical exam for heart issue? Yes No

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs? Yes No

6. Are you aware of having an allergic (**Or adverse**) reaction to any substance or medication? Yes No

If yes, please specify \_\_\_\_\_

7. Have you been a patient in the hospital during the past five years? Yes NO

8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S/H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stoke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No			

9. Have you lost or gained more than 10 pounds in the past year? Yes No

10. Do you have or had any disease, condition, or problem not listed? Yes No

If yes, please list: \_\_\_\_\_

11. **Women:** Are you pregnant or think you could be pregnant? Yes \_\_\_\_\_ Months No **Nursing?** Yes No

12. Do you use birth control prescriptions? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**History Review**

**Dentist Signature**

**Date**

**Registration Form**

**Patient Information**

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First Name \_\_\_\_\_

**Parent or Guardian**

Last Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Rent or Own Home \_\_\_\_\_

Date of Birth \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Township \_\_\_\_\_

E-mail \_\_\_\_\_

**Emergency Contact**

Phone # \_\_\_\_\_

Name \_\_\_\_\_

Soc Sec # \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Gender**      Male                       Female

**Language**      English                       Spanish                      Other \_\_\_\_\_  
**Race**            African American    Asian      American Indian    Caucasian      Pacific Islander      Native Hawaiian      Other

**Ethnicity**      Hispanic    Non-Latino                       Refused to report

**Military Status**  
 Active                                       Active Reserve  
 National Guard                       General discharge  
 Retired                                       Honorable discharge  
 Separated                                       Other discharge

**WIC**            Are you currently enrolled in the WIC program?                       Yes      No

**Income Level**      \$0-\$5,000    \$5,000-\$10,000    \$10,000-\$15,000    \$15,000-\$20,000    \$20,000-\$30,000    >\$30,000

**Homeless**         Yes             No

**Complete this section if you have insurance (Commercial, Medicaid, Medicare or Other)**

Name of Company \_\_\_\_\_

Effective Date \_\_\_\_\_

Insured Person \_\_\_\_\_

Insured Person's Date of Birth \_\_\_\_\_

Insured Soc. Sec. # \_\_\_\_\_

Group number \_\_\_\_\_

Patient Relationship to Insured Patient \_\_\_\_\_

ID Number \_\_\_\_\_

Attach copy of insurance card (Front & Back)

**Assignment and Release**

I Hereby consent to all treatment deemed necessary by the medical staff of NorthShore Health Centers. I authorize the release of any information necessary to process claim or any other collection process. I request that any money due to me for medical benefits be assigned to NorthShore Health Centers. I realize that I am Responsible for any and all difference. I agree to pay my fees at time of service and all fees associated with the collection process including but not limited to, attorney fees and court costs if my account becomes delinquent.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



# **SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES**

## **NorthShore Health Centers**

**Effective Date: April 14, 2003**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, Please contact, Privacy Officer at (219) 763-8112.

### **Who will follow this notice:**

- NorthShore Health Centers

This notice describes our privacy practices. All these entitled, sites, and locations follow the terms of this notice. In addition, these entitled, sites, and locations may share health information with each other for treatment, payment, or health care operations purpose described in this notice.

### **Our pledge regarding health information:**

We understand the health information about you and your health care is personal. We are committed to protection health information about you. We create a record of the care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you and follow the terms of the notice that is currently in effect.

### **How we may use and disclose health information about you.**

The following categories described different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- Appointment reminders
- To allow oversight of quality of the healthcare we provide
- To allow workers compensation claims

- AS required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or safety

The full details for all these uses are contained in the full NPP.

## **Your rights regarding Health information about you**

### **You have the following rights regarding health information we maintain about you:**

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosure
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from, Privacy officer at (219) 763-8112.

## **Changes to this notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

## **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

## **Other Uses of Health Information**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

- About a death we may be the result of criminal conduct;
- About criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

**Coroners, health examiners and Funeral directors:** We may release information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective services for the President and others:** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institutional.

## **Your rights regarding health information about you**

You have the following rights regarding health information we maintain about you:

**Rights to inspect and copy:** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to a privacy officer. If you request a copy of the information, we may charge a fee for the costs for copying, mailing or other supplies and services associated with your records.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, Submitted to a Privacy officer, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

**We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.** If you do, we agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you may make your request in writing to a Privacy officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

**Right to a paper copy of this notice:** You have the right to obtain a paper copy this notice at any time. However, at the time of first service rendered after April 14, 2003, it is required that you receive a paper copy. To obtain a copy, please request it from a Privacy officer.

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## **Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_, have received the Notice of Privacy Practices from  
NorthShore Health Centers.

X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of NorthShore  
Health Centers, state that \_\_\_\_\_ has been given our current  
Notice of Privacy Practices.

X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_





### Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree t the use of anesthetic, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. I agree to pay my fees at time of service and all fees associated with the collection process including but not limited to, attorney fees and court cost if my account becomes delinquent.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_





## Patient Responsibilities

It is our goal at NorthShore Health Centers to provide you with quality primary health care. We are entering into a partnership with you for your health and well-being. In order to provide you with the best care possible, your cooperation is expected and appreciated.

**Appointments-** Our hours are by appointment. If you are not able to keep your appointment, call and cancel. That time is reserved just for you. If you don't show up, valuable time is wasted!

**Medical History-** The more complete you are giving us your health history, the better able we are to serve you. This includes all medications that you take, including over the counter drugs.

**Language-** If you have any difficulty speaking or understanding English, if possible, bring an interpreter with you.

**Questions-** If there is any aspect of your care that you don't understand or aren't sure of, you need to ask us!

**Courtesy-** You should expect to be treated with respect and courtesy. We will respect your time and your intentions; we expect the same from you.

**Education-** You are the best advocate when it comes to your health. We strongly urge you to take advantage of health education classes as they are offered.

**Personal Information-** Keep us informed of any change in address or phone number.

**Updates-** Every year, you will need to provide us with a written record of your current income. (Pay stubs, tax statements, letter for employer)

**Surveys-** As a part of our quality improvement, we will periodically ask you to fill out a survey.

**Off Site Healthcare-** If you seek medical care outside of NorthShore Health Centers; you are responsible for any fees charges.

**Medical Advice-** You need to follow advice given by your Healthcare Provider. This includes taking medication only as prescribed and returning for follow up appointments. If you are having trouble getting your medication because the cost is too high, you need to tell your Healthcare Provider.

**\*REMEMBER, you are now part of NorthShore Health Centers. The success of this clinic depends our working together as a team. Help us to make this effort a success.**

**This list of patient responsibilities has been explained to me and I have received a copy. I understand that as a partner in my health care at NorthShore Health Centers, I am expected to follow the guidelines above.**

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Patient Signature

Date

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Witness



3564 Scottsdale St., 6450 US Hwy 6, Portage, IN 46368 2490 Central Ave.,  
3099 Central Ave., Lake Station, IN 46405 \*PH: 219.763.8112  
[www.northshorehealth.org](http://www.northshorehealth.org)

## DENTAL POLICY

1. Due to the long waiting list for dental care, you must arrive for your appointment 15 minutes early. If you are unable to keep your appointment, you must give a 24 hr. notice. If you are late, and you do not call to inform us, your appointment will be given to someone else.
2. If you do not show for your appointment and you do not call ahead of time to cancel or reschedule there will be a \$35.00 charge.
3. If you have one no-show, you will no longer be able to schedule a dental appointment at our facility. You will be seen but you will have to come into the office and wait for an opening.
4. There will be a limit of one (1) person in the operatory, unless the patient is under 10 or needs a translator.
5. If a child does accompany a parent, the child cannot be disruptive or treatment will be rescheduled.
6. If you don't speak or understand English, it is strongly suggested that you bring a translator to every appointment.

I have read the dental policy and understand that I can be denied dental services if I do not abide by the policy.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_





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3564 Scottsdale St., 6450 U.S. Highway 6, Portage, Indiana 46368 2490 Central Ave.,  
3009 Central Ave. Lake Station, Indiana 46405  
Ph 219.763.8112

[www.northshorehealth.org](http://www.northshorehealth.org)

Dear Patients,

To better serve you, our Social Services Coordinator has information for the following services, please check any you are interested in and return to the Receptionist so she can schedule an appointment for you:

- Consumer Credit Counseling of NW Indiana
- Division of Family & Children (Food Stamps/Medicaid).
- Family & Youth Services Bureau
- Indiana Legal Service, Inc.
- KV Works (Help with Employment)
- Family Planning NSHC
- Dental NorthShore Health Center
- Portage Adult Ed
- Porter County Family Counseling Center (No Children)
- Behavioral Health NorthShore Health Centers
- Pharmacy NorthShore Health Centers
- Salvation Army
- Social Security
- Spring Valley (Homeless Shelter)
- The Caring Place (Abused Women)
- Township Trustee (Help with rent, utilities.....)
- Vocational Rehabilitation Services
- WIC

NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_ Date: \_\_\_\_\_



***A Federally Qualified Health Center***

3564 Scottsdale St., 6450 US Hwy. 6, Portage, IN 46368 \* 3099 Central Ave.,  
2490 Central Ave., Lake Station, IN 46405 PH: 219.763.8112

**PAYMENT POLICY**

**Your health is important to us and we want to continue to be here when you need us!**

**NorthShore Is Not A “Free Clinic”, but is a Not-For-Profit Community Health Center which provides quality healthcare to all, regardless of ability to pay. Everyone must pay their sliding fee, which is determined by their income. (All are charged the base amount).**

- ◆ Your situation has been reviewed, and a reasonable fee has been determined. It is expected that you will pay that reasonable amount at time of service.
- ◆ If you have insurance: Medicare, Medicaid, or Private Insurance, notify intake personnel at the time of your interview.
- ◆ If your insurance situation should change in the future, notify us at the time you make an appointment.
- ◆ If you do not show for your appointment and you do not call within 24 hours to cancel or reschedule, there will be a \$25.00 charge.
- ◆ If you have two no-shows, you will no longer be able to schedule an appointment. You may walk in and wait until an opening becomes available.
- ◆ If you are sliding fee/self pay patient: You will be responsible for any additional charges that may be incurred, in addition to your office visit (labs, x-rays, EKG, etc).
- ◆ Payment due is expected when service is rendered. Any exceptions must be approved by billing coordinator.
- ◆ If payment is not received within 60 days, your account will be turned over to our collection agency. Patient agrees to pay all costs incurred with collection of any past due account, including a monthly service fee of \$5 and a minimum of \$125.00 in legal fees including court cost, and attorney fees.
- ◆ With each patient taking responsibility for their portion, we will be able to continue to provide you with quality health care.
- ◆ By working together, we will ensure that NorthShore Health Centers are available to all who need our services.

**I have read the payment policy and understand that the fee assigned to me is payable at the time of service.**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**