

Welcome to NorthStar. Please complete every section. Your health history directly affects how safely we can treat you — several common medicines change what we can do and when, so please list everything, including over-the-counter products and supplements. If a question does not apply, write "N/A." Ask us about anything that is unclear; we are glad to help you fill this out.

Date Location Chart / MRN
☐ Briarwood / Queens ☐ Manhattan — 333 E 34th St, Suite M1 ☐ Commack — 283 Commack Rd, Suite 130

1. PATIENT INFORMATION

Last name First name Middle
Preferred name Date of birth Last 4 of SSN Pronouns
Street address Apt # City
State ZIP Mobile phone Other phone
Email Employer or school
Emergency contact Relationship Phone
Preferred pharmacy & cross streets Pharmacy phone
Who may we thank for referring you? Primary physician

Preferred language and assistance

Preferred language Do you need an interpreter?
☐ No assistance needed ☐ Interpreter requested ☐ Large-print materials
☐ Wheelchair access needed ☐ I would like help completing forms

2. RESPONSIBLE PARTY — complete only if someone other than the patient is responsible for payment

Last name First name Relationship to patient
Date of birth Mobile phone Email
Address, if different from the patient's
☐ Responsible party is currently a patient of this practice ☐ Patient is a minor — parent or guardian completing this form ☐ Signer holds health care proxy or power of attorney

3. DENTAL INSURANCE — bring your card; we will verify your benefits for you

Primary plan

Insurance company Member / subscriber ID Group #
Name of insured Insured's date of birth Relationship to patient
Insured's employer or union Plan phone number

Secondary plan, if any

Insurance company Member / subscriber ID Group #
Name of insured Insured's date of birth Relationship to patient
☐ No dental insurance ☐ I will self-pay ☐ Please verify my benefits before treatment ☐ I have a health savings / flexible spending account

4. DENTAL HISTORY

What brings you in today? What would you most like us to fix?

Previous dentist Date of last dental visit Date of last x-rays

Have you had any of the following? (check all that apply)

NEW PATIENT REGISTRATION & CONSENT

Patient: _____

- | | | | |
|---|--|--|--|
| ☐ Bleeding gums | ☐ Loose teeth | ☐ Broken or lost fillings | ☐ Sensitivity to cold |
| ☐ Sensitivity to heat | ☐ Sensitivity to sweets | ☐ Pain when biting | ☐ Food catching between teeth |
| ☐ Bad breath or bad taste | ☐ Dry mouth | ☐ Sores or lumps in the mouth | ☐ Jaw clicking or popping |
| ☐ Jaw pain or limited opening | ☐ Clenching or grinding | ☐ Headaches on waking | ☐ Difficulty chewing |
| ☐ Dentures or partials that do not fit | ☐ Gum (periodontal) treatment | ☐ Root canal treatment | ☐ Orthodontics / braces |
| ☐ Teeth whitening | ☐ Snoring or sleep apnea | ☐ I avoid smiling in photos | ☐ Dental anxiety or fear |

Implant and surgical history

- | | | | |
|--|---|--|---|
| Have you had dental implants placed before? | ☐ Y ☐ N | Has an implant or bone graft ever failed? | ☐ Y ☐ N |
| Have you had a bone graft or sinus lift? | ☐ Y ☐ N | Have you had teeth removed surgically? | ☐ Y ☐ N |
| Any problem with healing after dental surgery? | ☐ Y ☐ N | Any problem with numbness after dental work? | ☐ Y ☐ N |

How often do you brush? _____ How often do you floss or use a water flosser? _____ Last cleaning _____

5. MEDICAL HISTORY

Why we ask in this much detail. Several widely used medicines change the safety and the success of implant surgery and sedation — bone-strengthening drugs, blood thinners, steroids, and the newer weight-loss and diabetes injections among them. Please list everything, even if you think it is unrelated, and tell us if anything changes before your procedure.

Physician's name _____ Physician's phone _____ Date of last visit _____

Please answer each question

- | | | | |
|--|---|--|---|
| Are you in good general health? | ☐ Y ☐ N | Has your health changed in the past year? | ☐ Y ☐ N |
| Are you under the care of a physician now? | ☐ Y ☐ N | Have you ever been hospitalized or had surgery? | ☐ Y ☐ N |
| Have you ever had a serious head or facial injury? | ☐ Y ☐ N | Have you ever had radiation to the head or neck? | ☐ Y ☐ N |
| Have you ever had chemotherapy or immunotherapy? | ☐ Y ☐ N | Do you have an artificial joint, pin or plate? | ☐ Y ☐ N |
| Do you have an artificial or repaired heart valve? | ☐ Y ☐ N | Have you been told to take antibiotics before dental care? | ☐ Y ☐ N |
| Do you have a pacemaker or defibrillator? | ☐ Y ☐ N | Do you bruise or bleed easily? | ☐ Y ☐ N |
| Have you ever had a blood transfusion? | ☐ Y ☐ N | Do you use tobacco, vape, or nicotine pouches? | ☐ Y ☐ N |
| Do you drink alcohol? If yes, how much per week? | ☐ Y ☐ N | Do you use cannabis or other recreational drugs? | ☐ Y ☐ N |
| (If applicable) Are you pregnant or trying to become pregnant? | ☐ Y ☐ N | (If applicable) Are you breastfeeding? | ☐ Y ☐ N |

Have you ever had any of the following? (check all that apply)

- | | | | |
|--|---|--|--|
| ☐ Anemia | ☐ Arthritis / rheumatism | ☐ Asthma | ☐ Autoimmune disease |
| ☐ Back or neck problems | ☐ Bleeding disorder | ☐ Blood clots / DVT | ☐ Cancer |
| ☐ Chemical dependency | ☐ Circulatory problems | ☐ Congenital heart defect | ☐ COPD / emphysema |
| ☐ Diabetes — Type 1 | ☐ Diabetes — Type 2 | ☐ Epilepsy / seizures | ☐ Fainting or dizziness |
| ☐ Glaucoma | ☐ Heart attack | ☐ Heart murmur | ☐ Heart surgery or stents |
| ☐ Hepatitis (type: _____) | ☐ High blood pressure | ☐ HIV / AIDS | ☐ Immune deficiency |
| ☐ Kidney disease or dialysis | ☐ Liver disease | ☐ Low blood pressure | ☐ Mitral valve prolapse |
| ☐ Osteoporosis / osteopenia | ☐ Persistent cough | ☐ Respiratory disease | ☐ Rheumatic fever |
| ☐ Shortness of breath | ☐ Sinus problems | ☐ Sleep apnea (CPAP?) | ☐ Stroke or TIA |
| ☐ Swelling of feet or ankles | ☐ Thyroid disease | ☐ Tuberculosis | ☐ Ulcer / reflux / GERD |
| ☐ Bariatric (weight-loss) surgery | ☐ Organ transplant | ☐ Eating or swallowing difficulty | ☐ Other (describe below) |

Medicines — please tell us if you take, or have ever taken, any of these

- | | | |
|--|--|---|
| ☐ Blood thinner (warfarin, Eliquis, Xarelto, Plavix, aspirin) | ☐ Bone-strengthening drug (Fosamax, Boniva, Actonel, Reclast) | ☐ Prolia or Xgeva (denosumab) |
| ☐ Steroids (prednisone and similar) | ☐ GLP-1 injection (Ozempic, Wegovy, Mounjaro, Zepbound) | ☐ Insulin or diabetes medication |
| ☐ Immune-suppressing or biologic drug | ☐ Chemotherapy or targeted cancer therapy | ☐ Blood pressure or heart medication |
| ☐ Antidepressant / anti-anxiety medication | ☐ Opioid pain medication | ☐ Hormone therapy or birth control |

If you take or have taken a bone-strengthening drug, which one and for how long? _____

List every medicine and supplement you take, with the reason for it (attach a list or a photo of your bottles if easier):

Allergies and reactions — medicines, latex, metals, foods, anesthetics (describe what happens):

Anything else we should know about your health, or anything you would like to tell us privately:

6. HOW WE MAY CONTACT YOU — you may change any of these at any time

We use calls, texts and email for appointment reminders, test and biopsy results, treatment plans, and billing. Message and data rates may apply; you can reply STOP to any text to stop receiving them.

You may contact me by:

- | | | |
|--|--|--|
| ☐ Text message to my mobile | ☐ Phone call to my mobile | ☐ Phone call to my other number |
| ☐ Email | ☐ Mail to my home address | ☐ Patient portal only |

You may leave a detailed message:

- | | | | |
|---|--|---|---|
| ☐ Yes, on my voicemail | ☐ Yes, with the people listed below | ☐ Appointment times only — no clinical details | ☐ No messages — please keep trying |
|---|--|---|---|

People we may speak with about your care (name and relationship)

7. CONSENT FOR CARE AND USE OF MY INFORMATION

- **Consent to examination and routine care.** I authorize NorthStar Implant Dentistry, P.C., its dentists, contractors and staff to examine me, take x-rays, photographs and scans, and provide dental care for this visit and for later visits. **Surgery, sedation and other significant procedures are consented to separately**, on their own forms, after a discussion of the risks, benefits and alternatives. I may revoke this consent in writing at any time.
- **My dental record.** This practice is required by law to keep records of my care. Those records are used and disclosed only as permitted by state and federal privacy law, as described in the practice's Notice of Privacy Practices, which I may ask to see at any time and which may be updated from time to time.
- **Insurance.** I authorize this practice to release the information necessary to process my claims, and I assign to the practice the dental benefits otherwise payable to me for the services provided. I authorize the use of this signature on my insurance submissions. This authorization ends when my current treatment plan is complete or one year from the date I sign, whichever comes first.
- **Accuracy.** To the best of my knowledge the information I have given is complete and correct, and **I will tell this office if my health, medicines or insurance change** — including between the day I sign this and the day of any procedure.

- | | | |
|---|--|--|
| ☐ I received the Notice of Privacy Practices | ☐ I declined a copy of the Notice | ☐ Copy of this packet offered to me |
|---|--|--|

8. FINANCIAL POLICY

We would rather talk about money before treatment than after it. Please read this section and ask us anything.

- **Estimates before treatment.** Before any treatment beyond an examination, you receive a written treatment plan with the fees, what we estimate your plan will cover, and your estimated share. An estimate is not a guarantee of what your plan will pay.
- **Your insurance is a contract between you and your plan.** We are not a party to it. As a courtesy we verify your benefits and file your claims, and we will bill a secondary plan once the primary has paid. It is your responsibility to confirm that your treating doctor is in your plan's network. **All charges are ultimately your responsibility**, including anything your plan does not cover.
- **What is due when.** Co-payments, deductibles and the estimated patient portion are due at the time of service. Surgical and implant treatment may require a deposit when it is scheduled. After your plan responds, we bill you for any remaining balance or refund any overpayment.
- **If you do not have insurance.** Payment in full is due at the time of service unless we have approved a written payment arrangement in advance. We will tell you about any financing or membership options we offer.
- **Past-due balances.** A balance unpaid 30 days after our statement may be charged a late fee of 1% per month (12% per year), which is below the New York civil usury limit. If an account must be placed with a collection agency or attorney, you agree to pay the reasonable costs and fees actually incurred, to the extent New York law permits them.

- **What we will not do.** Consistent with New York's Fair Medical Debt Reporting Act, **we do not report patient balances to consumer credit reporting agencies.** If you are having trouble paying, call us — we would much rather arrange a plan than send an account out.
- **Returned payments.** A service charge may be applied to any check or other payment returned unpaid.

Appointments

- Surgical and sedation appointments reserve a long block of time and a surgical team. Please give us at least **two business days'** notice to change or cancel one, and 24 hours for any other appointment. A fee may be charged for a late cancellation or a missed appointment, and a deposit may be required to reschedule.

Late cancellation / missed appointment fee _____

Deposit required for surgical scheduling _____

9. SIGNATURES**Please initial each line:**

____ The health history I have given is complete and accurate, and I will report any change before my treatment.

____ I consent to examination, x-rays and routine dental care as described in Section 7, and I understand that **surgery and sedation require their own separate consent.**

____ I have read and agree to the financial policy in Section 8, including the appointment and cancellation policy.

____ I have been offered a copy of this packet and of the Notice of Privacy Practices.

Signature of patient or legal representative_____
Date_____
Time_____
Print name_____
If not the patient: relationship and legal authority (parent, guardian, health care proxy, power of attorney)_____
Witness signature (optional)_____
Print name_____
Date**OFFICE USE**

- | | | | |
|--|---|--|---|
| ☐ Photo ID and insurance card scanned | ☐ Benefits verified | ☐ Health history reviewed with patient | ☐ Medical clearance needed |
| ☐ Premedication indicated | ☐ Blood thinner protocol flagged | ☐ Bone-strengthening drug flagged (MRONJ) | ☐ Packet scanned to chart |

Reviewed by _____ Date / time _____ Next update due _____

Staff notes / items to follow up before treatment:

Retention: scan this packet into the patient record at the first visit. Health history is re-confirmed at every surgical visit and re-taken at least once a year, or sooner if the patient reports a change.