NANCY NORLING DDS

Consent for Use and Disclosure of Health Information and Verbal Release

I, _____ _____, have received and reviewed a copy of Dr..Norling's Dental Office Notice of Privacy Practices and Security Policies and Procedures.

Signature_____Date_____

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information.

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

Name_____ Date of Birth_____

I hereby authorize Dr. Norling and/or members of her staff to release the following Personal health information: 1) Dental services claims information. 2) Prescriptions, Diagnostic, treatment, and/or care management services 3) Review required by HHS or HIPAA-compliant health care operations. 4) Communications from the dental office by telephone, email, fax, postal services or any means that the office feels efficient to contact me regarding the above mentioned statements.

My Consent Effective: Today's Date_____

Continue Indefinitely: I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patients rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient_____Date_____

Personal Representative_____Date_____

If there are other persons or entities that you would like us to be able to speak to about your care please list below

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

OK to leave message containing confidential information on voicemail to this and/or these numbers:

HOME_____ CELL_____ WORK_____

FORM A Smile Assessment Questionnaire

NANCY norling DDS

Comprehensive
Cosmetic and
Restorative
Dentistry

NAME_____

1. If there was anything you could change about your smile, what would it be?

2. What is your reason for the appointment?

3. In our work together, what are your goals and objectives?

4. What qualities are you looking for in a dentist?

5. What role does your insurance coverage have in achieving your objectives?

6. What do we need to know about you in order for us to work well together?

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1. Do you like the color of your teeth? Y / N
2. Would you like to change the way your teeth or gums are shaped? Y / N
3. Do you have gaps or spaces between your teeth that you would like filled in? Y / N
4. Are your upper front teeth straight? Y / N
5. Are your lower front teeth straight? Y / N

FORM D Finance Policy

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Our commitment is to inform you of the fees for all dental treatment. At your request we will submit pre-estimates to your insurance company when applicable. We also offer affordable payment plans through Care Credit Co. and will make available application forms when needed. The following is our financial policy:

A. All cosmetic dentistry appointments will require full payment on the day of the appointment.
B. Major treatment appointments (crowns, onlays and bridges) will require one-half down at the time of the appointment and balance at completion. **If you have insurance we will be happy to process your claim and your insurance company will reimburse you directly.**
C. Preventive treatment appointments (cleanings, exams, x-rays and sealants), restorative appointments (fillings), and periodontal treatment appointments (gum disease, root planing and scaling) will require payment at the time of the visit**. If you have insurance we will be happy to process your claim and your insurance company will reimburse you directly.**
D. Method of payment:

1. Cash, personal checks
2. Visa, MasterCard, American Express or Discover
3. Care Credit health card (please inquire with our office manager)

I am aware that Dr. Norling is a non-participating provider for all network insurance plans. This means that if my dental insurance plan allows me to go out of network to see the dentist of my choice, my out of pocket expense will be higher than seeing a participating provider. If you have questions we ask that you contact your insurance company or your employer.

Patient Signature:_____Date_____

FORM C Dental Treatment Consent

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I hereby authorize Dr. Nancy Norling and her assistants to perform the following dental treatment plan. If any unforeseen condition arises in the course of treatment calling for procedures in addition to, or different from those now contemplated, I wish to be informed and involved in the decision for alternative treatment.

I am informed and fully understand that inherent in any type of dentistry includes the possibility of unavoidable complications. I am aware that the practice of dentistry is not an exact science. I do not hold Dr. Nancy Norling responsible for any common complications of dentistry. This may include teeth sensitivities, the need for endodontic treatment, TMJ problems, and gingival or mouth tissue sensitivities. I further realize that in spite of the possible complications, my contemplated dental work is desired by me.

I realize that it is mandatory that I give an accurate and complete medical history, and follow all instructions as directed by Dr. Nancy Norling to ensure optimum results from my dental treatment.

The following dental procedures may be included in my treatment plan:

- Dental examination
- Dental x-rays
- Diagnostic photographs
- Prophylaxis
- Fluoride treatment
- Sealants
- Restorative treatment
- Cosmetic treatment
- Periodontal treatment
- Endodontic treatment
- Oral surgery
- Orthodontic

Any questions about my proposed dental treatment have been fully answered. I have read this statement and understand it completely.

Parent/Guardian/_____ Signature_____ Date_____

Doctor_____ Signature_____Date_____

PATIENT REGISTRATION

Today's Date_____

Patient First Name: _____ Patient Last Name: _____ Middle Initial:_____

Preferred Name: _____

Patient is : □ Responsible Party

Responsible Party: (Responsible Party is policy holder and/ or parent/ guardian of patient)

Patient First Name:_____ Patient Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency contact name and phone # _____

Birth date:_____Social Security #:_____Drivers Lic#:_____

Patient Information:

Address: _____Address 2: _____

City, State, Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ Emergency contact name and phone #_____

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Pharmacy: _____Phone#_____How did you hear about our practice?_____

Primary Dental Insurance Information:

Name of policy holder:_____ Relationship to policy holder: ○Self ○Spouse ○Child ○ Other

Group #:_____ Subscriber ID: _____

Insured Social Security #: _____ Insured Birth date:_____

Employer Name:_____ Insurance Company Name:_____

Ins. Co.Address:_____ City, State, Zip:_____

Secondary Dental Insurance Information:

Name of policy holder: _____Relationship to policy holder: ○Self ○Spouse ○Child ○ Other

Group#:_____ Subscriber ID:_____

Insured Social Security #: _____Insured Birth date:_____

Employer Name:_____ Insurance Company Name:_____

Ins. Co. Address:_____City, State, Zip_____

Patient Signature/Parent or Guardian_____ Date_____

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Dental Insurance And You

The Patient Comes First!
You deserve the right care and the right compensation. Dr. Nancy Norling's dental treatment plans are tailored to provide you with the needed quality dental care. Dental insurance programs are designed to help with the financial coverage of your dental treatment.

Your Plan's Coverage
During the last decade, dental benefit plans became an integral part of health care planning. While these plans are made available to employees through companies, unions and associations, each may vary considerably. Your employer, the purchaser of the insurance plan, selects the range of benefits. The insurance plans may provide only limited coverage, or provide coverage of only specific services, such as preventive dental care.

You and your Insurance Plan
Typical criteria and terms espoused by insurance carriers include:

"Reasonable and customary fees"
"Yearly maximums"
"Pre-authorization"

Each of these criteria and terms varies by plan and insurance carrier. To ensure you receive maximum benefits, we recommend that you read your insurance booklet and become familiar with your specific plan requirements. Low reimbursement may be the result of coverage purchased for the insurance plan. If you feel the dental benefits are inadequate, discuss this matter with your employer so that alternatives can be investigated.

You and Your Insurance Claims
We can help. We will process all of your insurance claims expeditiously. All you need to do is fill out the top 'personal information' section of your insurance form and bring it to our office or bring you current insurance card with you.

Dental Treatment Payment Policy
We require payment at the time of treatment. Your insurance company will send payment directly to you in a timely manner.
Dr. Norling is a non participating provider for **Delta Dental** and **dental PDO's**. Many patients still choose to see Dr. Norling because they value the quality of care that they receive here.

Dr. Nancy Norling and her staff take pride in providing comfortable, quality dental care.

DIRECTIONS

NANCY**norling**DDS
1660 S. Hwy 100, Suite 122
Minneapolis, MN 55416
(952) 544-4129

Arriving from the EAST

Take I-94 West to I-394 West.
Exit on Highway 100 South to Cedar Lake Road and follow the curve to the right.
Our office building is the FIRST parking lot on right (across from Podany's Office Furniture) when you exit on Cedar Lake Road.

We are on the ground floor of 1660 Parkdale Plaza.

Arriving from the WEST

Take I-394 East to the Xenia/Park Place Blvd. exit.
Turn south (right) on Park Place Blvd. to Parkdale Drive.
Turn left on Parkdale Drive.
Our office building is the LAST parking lot on the left-hand side, before the entrance onto Highway 100 (across from Podany's Office Furniture).

We are on the ground floor of 1660 Parkdale Plaza.

Arriving from the SOUTH

Take Highway 100 North to the Cedar Lake Road exit (Cedar Lake Road runs parallel to Highway 100 for a short time).
Loop around the Fiat car dealership on the right-hand side and go under Highway 100.
At the stoplight, merge right onto Parkdale Drive.
Our office building is the LAST parking lot on the left-hand side, before the entrance onto Highway 100 (across from Podany's Office Furniture).

We are on the ground floor of 1660 Parkdale Plaza.

Arriving from the NORTH

Take I-694 West to Highway 100 South.
Exit on Cedar Lake Road and curve to the right.
Our office building is the FIRST parking lot on the right (across from Podany's Office Furniture) when exiting Cedar Lake Road.

We are on the ground floor of 1660 Parkdale Plaza.

TIME 1:39 PM Dr. Nancy Norling DATE 10/24/2013

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____