Thank you for choosing our office to assist you with your dental needs. Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____

Date of Birth _____ Sex:_____

If minor, name of legal guardian_____

Home phone _____ Mobile phone _____

Work phone_____

Email address:_____

Mailing address _____ City _____State _____ Zip _____

Employer _____ whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: Not covered by dental insurance Y N

Your SS# : _____

Member ID#_____

Dental Insurance Co._____ Group number_____

Claims Address_____

Covered by spouse's insurance? yes no

Spouse's Name _____

Spouse's dental insurance company _____

Group number _____ Spouse's birthday _____ SS# or Member ID# _____

MEDICAL HEALTH HISTORY Do you have, or have you had any of the following?

(Please check any that apply)

- Are you required to Pre-medicate before any dental treatment?
- Blood Problems (Anemia)
- Blood transfusion
- Heart problems , Heart murmur, mitral valve prolapse, heart defect, Heart Pacemaker
- Stroke
- Bone or joint problems , Artificial joint or valves
- High or low blood pressure (circle one)
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis, jaundice or other liver disease
- Diabetes TYPE 1 or TYPE 2
- Epilepsy or Neurological disorders
- Thyroid problems
- Arthritis
- Herpes or cold sores q AIDS or HIV positive
- Cancer/Tumor
- Abnormal bleeding after any surgery (heavy bleeder)
- Hay fever or sinus trouble
- Allergies , Asthma

Are you allergic to, or have you reacted adversely to any of the following?

Latex, Penicillin or other antibiotics, Local anesthetics , Codeine or other narcotics ,Sulfa drugs, Barbiturates, sedatives, or sleeping pills , Aspirin

Other:_____

Are you taking any of the following? Aspirin , Anticoagulants (blood thinners e.g. Coumadin) Antibiotics or sulfa drugs , High blood pressure medicine , Antidepressants or tranquilizers , Insulin other diabetes drugs, Nitroglycerin , Cortisone or other steroids , Osteoporosis (bone density) medicine , Natural supplements , Other:_____

Women: Are you pregnant or plant to become pregnant?

Taking hormones or contraceptives? Do you smoke, vape or use tobacco? Yes No

Name of your primary medical physician:_____

Phone number_____

Signature of patient (or parent) _____

Date _____

DENTAL PLUS
775 ROUTE 1 SOUTH
EDISON, NJ 08817
732-287-6611

FINANCIAL CONSENT

I understand that I am financially responsible for all charges whether or not they are covered by the insurance. If my account is placed in collection, I understand that I am responsible for 33.33% of collection or attorney and all fees incurred pertaining to this collection account. Past due bills may be subject to interest charges at the rate of 1.5% per month.

Signature of Patient: _____

Medicaid-State of New Jersey Information

This office does not participate in the State of NJ Medicaid program, therefore, if you have Medicaid Insurance, you will be responsible for the office visits.

I understand the above terms.

Signature of Patient: _____

Witness (Doctor's Name or Office Staff): _____

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APPOINTMENT POLICIES

We are here to help all of our patients to gain and maintain dental health. Unfortunately, we have only a limited amount of chair time available to do so. Our time is not only valuable to us, but also to your fellow patients. Please regard our office policies and courtesies.

1) **If it is necessary to cancel an appointment, please do so within 24 hours prior to your appointment to avoid a cancellation fee.**

2) **If a patient does not show for their appointment without notice to our staff, we reserve the right to charge a fee for that broken appointment.**

Our fee: $75.00
Patient signature: _____

RELEASE AUTHORIZATION

I hereby authorize the above named dentist(s) to provide any insurance company, claim administrator, and consulting healthcare professionals the information concerning healthcare, advice, treatment, or supplies provided.

This information will be used for the purpose of evaluation and administering claims for benefits.

Patient/guardian signature: _____
Date: / /

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EDISON, NJ 08817
732-287-6611

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information in order to:

- Carry out treatment, including direct and indirect treatment by other healthcare providers involved in my treatment
- Obtain payment form the third party payers (e.g. my insurance company)
- Complete the day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of the *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosure of my protected health information and my rights under HIPAA. I understand that the office reserves the right to change this notice at any time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that the office is not required to agree to these restrictions. However, if an agreement is reached, the office is then bound to comply with the restrictions.

I understand that I may revoke this consent *in writing* at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print patient name: _____

Relationship to Patient, if not self: _____

Signature: _____ Date: / /