Dental Cosmetic Center Of Piscataway

Patient Information

Patient Name_____ Date: _____
Last, First **MI** (Preferred Name)

If under 18years old, name of responsible party: _____, relations of that person to the patient: _____

Gender: __F __M Family Status: __Child __Single __ Married

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ *{ext}* _____ (Cell) _____
Best time to call: _____ E-mail Add: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information/ Medical History

Date of Last Dental Visit: _____ **Reason for this visit:** _____
Name of the Dentist last visited: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/ HIV Positive
- ☐ Allergies _____
  - ☐ Latex
  - ☐ Local Anesthesia
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints/ Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Coronary Insufficiency
- ☐ Coronary Occlusion
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack(s)
- ☐ Heart Problem
- ☐ Heart Murmur/ MVP
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker/ Heart Surgery
- ☐ **Pregnancy (current time)**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER:
  _____
  _____
- ☐ Medications:
  (Including non- prescription)
  _____
  _____
  _____

- Are you wearing removable dental appliances? ☐Yes ☐No
  If yes, please explain: _____
- Do you smoke or use tobacco of any type? ☐Yes ☐No ☐Stopped/ not anymore
  If yes, please explain: _____
- Do you drink? ☐Yes ☐No
  (Drinking thins your blood, for any major procedure you <u>can NOT</u> drink for 24hrs before that procedure)
- <u>For women</u>: Are you nursing? ☐Yes ☐No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ _____
Signature of patient, parent or guardian Date

Spouse or Responsible Party Information (Financially)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services (Please take the time to Read)

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or their assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I hereby authorize and direct the dentist(s) assisted by other dentist(s) and/ or dental auxiliaries of his/ her choice to perform upon myself or my child as per the dental treatments discussed. No guarantee has been given to me that the proposed treatment will be curative and/ or successful to my complete satisfaction. I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment or that of my child. I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time I choose to terminate it.

Regarding Drugs and Medication: I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/ or anaphylactic shock (severe allergic reaction).

Regarding treatment plan and possible changes: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/ all changes and additions as necessary.

Regarding Crowns, Bridges and Caps: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation.

Regarding Dentures, complete or partials: I realize that full or partial dentures are artificial, constructed of plastic, metal and/ or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the teeth in wax (what we call the “try-in visit”). I understand that most dentures require relining approximately 3 to 12 months after initial placement. The cost for this procedure is not included in the initial denture fee.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Dental Cosmetic Center Of Piscataway

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone: E-mail:
Social Security #:

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Dental Cosmetic Center Of Piscataway 1100 Centennial Avenue,Ste 101 Piscataway, NJ 08854 (732)562-1111

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE
I, , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.
HIPAA web site: **http://www.**hhs**.gov/ocr/hipaa/finalreg.html**

You May Refuse to Sign This Acknowledgement*

I _____, have received acknowledgement of this office's Notice of Privacy Practices.

_____ _____
Signature Date

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)
_____