

Date: _____

Patient Information

Patient Name: _____ DOB: _____

Last Name

First Name

Nickname: _____ Gender (M/F): _____ Marital Status: _____

Social Security #: _____ - _____ - _____ Email Address: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Phone #'s: Home: _____ Work: _____ Ext. _____

Cell: _____ Best Time To Call: _____

Referral Information

How did you hear about us? _____

Spouse or Responsible Party Information (If Different from above)

Name: _____ DOB: _____

Last Name

First Name

MI

Gender (M/F): _____ Marital Status: _____ Social Security #: _____ - _____ - _____

Email Address: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Phone #'s: Home: _____ Cell: _____

Insurance Information

Primary

Name of Insured: _____

Last Name

First Name

MI

Employer: _____

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

Patient's Relationship to Insured: Self Spouse Child Other

Do you have secondary coverage? Yes No

In Case of Emergency Contact

Name of Contact: _____

Last Name

First Name

MI

Patient's Relationship to Contact: Spouse Child Other

Phone #'s: Home: _____ Cell: _____ Work: _____

Reverse Side →

Medical/Dental History (Check the boxes that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Oral Herpes |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> AIDS, HIV | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Jaundice/Liver Disease |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Headaches | <input type="checkbox"/> Immunosuppressive |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Other: _____ |

Do you have any of the following? If yes please list, or explain

Allergies to Anesthetics: _____

General Allergies: _____

Allergies to Medicine/Drugs: _____

Have you ever had an adverse reaction to any dental treatment? If yes please explain.

YES NO

Are you allergic to latex? YES NO

Does your Physician require you to take antibiotics prior to dental treatment? YES NO

Please List Medications/doses you are currently taking: _____

Are you under the care of a physician? _____

Please List all Major Surgeries _____

Is there anything else we should know about your medical history? _____

Do you grind your teeth at night or suffer from Jaw pain? _____

Women: Do you suspect that you are pregnant? YES NO

Are you taking any Birth Control? YES NO

Are you nursing? YES NO

When was your last dental cleaning? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature: _____ **Date:** _____

Reverse Side →

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
HIPPA**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 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, and of other important matters about you protected health information. A copy of Our Notice accompanies 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 anytime by contacting Jillene Dye. Telephone #: (732) 951-0099

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.

Our Policy: Missed appointments without cancellation will result in a \$35 charge. To avoid being charged please cancel you're appointment 24 hours prior to your appointment.

Consent: In order to comply with federal regulations regarding your privacy, we ask that you complete the following. Do you authorize this office to leave information via:

Home Phone: YES NO Cell Phone: YES NO E-mail: YES NO

If you authorize us to discuss information with another person, please provide their information below. Without your written permission, we are UNABLE to discuss any information with anyone.

NAME	RELATIONSHIP	CONTACT NUMBER
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I, _____, have had full opportunity to read and consider the contents of this
(Print Name)

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

Dentistry at South Brunswick and Your Insurance Plan

Our Office Financial Policy

The staff at Dentistry at South Brunswick is pleased that you have insurance assistance to help with the cost of your dental care. We would like to help you obtain the maximum use of your dental plan benefits. Please read the following information on our insurance claims process so that we can work together to ensure this assistance.

Do You Accept My Insurance? How Much Will They Pay?

We currently accept all private care insurance plans (plans that do not *require* you to select a dentist from a pre-determined list). We estimate your portion based on the most up-to-date information on your plan, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a “pre-treatment authorization” with your insurance company prior to treatment.

I Thought I Paid My Portion But I Received A Bill. Why?

We base the patient portion of your bill on our most current information on your dental plan, but there are many factors that can affect this estimate. There may be an individual or family deductible or you may have received treatment in another office which is not calculated into our database. Sometimes you may need to be referred to a specialist for care, which also is applied to your annual maximum benefits. Insurance companies do not notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

Insurance Didn't Pay. Now What?

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Dentistry at South Brunswick reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. It is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Financial Options

Dentistry at South Brunswick requests payment in full for your portion (co-pay) at the time of service. We accept cash, check, MasterCard, American Express, Discover, and Visa. If you are in need of an extended finance option, we also work with Care Credit, Chase Healthcare Advance, and Capital One. They offer plans up to 24 months with no interest, depending on your treatment plan needs. Just ask our Financial Coordinator Jill and she will give you everything you need.

We welcome you and your family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dentistry at South Brunswick.

Signature

Date