East Windsor Dental Arts

Welcome

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

PERSONAL

Name____
Last First MI (Preferred)
Birthdate_________________ SS#______________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N
Home Phone___________________ Wireless Phone_____________________ Work Phone___________________
Email____
Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Address____
City_________________________________ State________Zip______________________
Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime
How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

Emergency Contact___________________________ Phone__________________Relationship_____________________

INSURANCE POLICY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name____Subscriber ID # _________________________
Insurance Company ____Phone________________________________
Employer______________________________Group Name________________________Group #___________________
Please present insurance card to receptionist.

Do you have a second insurance policy? ( ) Y ( ) N

DENTAL HISTORY

Reason for today's visit____ Are you in pain? ____________________
New patients:
Name of former dentist____ City/State_________________________
Date of last cleaning and exam______________________ Date of last x-rays_______________________

Comments:

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.
For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

Signature____ Date________________________

INSTRUCTIONS:
To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office–to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered. Use the pen supplied by the office.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & telephone # of your physician ______________________________

____

2. Date of last visit to your doctor __________ Purpose of visit ______________________

3. Do you suffer from any disability? __________ If yes, describe ______________________

____

4. Have you ever, or do you now take illegal drugs? ________ Is yes, what drugs, and when taken? ________

____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-positive? _______ If yes, describe and provide current status. ________

____

6. Do you now have, or have you ever had a venereal disease? _________ If yes, describe. ______________

____

7. Have you ever had, or do you now have hepatitis? _______ If yes, describe. ______________________

8. For females: Are you pregnant? ______________ If yes, when are you due? ______________

9. For females: Are you taking birth control pills? __________ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

10. Are you taking any drugs or medications? ________ If yes, list and describe amounts and purpose. ________

____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication? ________ If yes, describe. ______________________

12. Have you lost weight recently? _______ If yes, describe. ______________________________

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? ______________

____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? ______________

15. Stomach or intestinal disease? ______________________________________

16. Abnormal blood pressure, excessive bleeding, or anemia? ______________________________

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17. Breathing problems, asthma, tuberculosis, or hay fever? ______________________________

____

18. Cancer, X-ray treatments, or chemotherapy? ______________________________

____

19. Diabetes? ______________________________

20. Kidney problems or renal dialysis? ______________________________

21. A stroke, convulsions, or fainting spells? ______________________________

____

22. Tumors or growths? ______________________________

____

23. Arthritis or rheumatism? ______________________________

24. Have you ever had a major operation? __________ Is yes, describe. ______________________________

____

25. Have you ever had a serious injury to your head or neck? __________ If yes, describe. ______________________________

____

26. Are you on a special diet? __________ If yes, for what reason and describe. ______________________________

____

27. Do you smoke? __________ If yes, describe type and quantity. ______________________________

28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? __________ If yes, describe.

____

29. Are there any other problems about your health of which you are aware? ______________________________

____

DENTAL HISTORY

Date of your last visit to a dentist ______________________________

Reason for your last visit (or series o visits) ______________________________

Do you have any of your X-rays or dental records? ______________________________

In respect to any previous dental treatment have you:

30. Ever fainted? ______________________________

____

31. Had an allergic reaction? ______________________________

____

32. Had abnormal bleeding? ______________________________

33. Any other complications during or following dental treatment? __________ If yes, describe. ______________________________

____

34. Do your gums bleed on brushing or eating? ______________________________

35. Does food catch between your teeth? ______________________________

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36. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? ______________________________

37. Are any of your teeth sensitive to heat, cold, or pressure? ______________________________

38. Do you grind your teeth or clench your jaws? ______________________________

39. Do you have pain or clicking in the jaw joint around your ear? ______________________________

40. Have your jaw muscles ever been sore? __________ If yes, describe. ______________________________

41. Are there any sores or growths in your mouth? ______________________________

42. Do any of your teeth ache? ______________________________

43. Do you have any other dental complaint? ______________________________

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or health practitioners.

Person completing the form: Signature ______________________________

Witness ______________________________ Print Name ______________________________

If other than patient, indicate relationship ______________________________ Date ____/____/____

Dentist's History Review & Significant Findings

____

Signature Dr. ______________________________ Date ____/____/____

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DENTAL OFFICE INFORMED CONSENT

It is very important to us that you, our patient, understand the treatment we are recommending and any invasive procedures which we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form as you understand that there is risk associated with dental procedures and all of your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk of complications. As with all medical treatment to ones body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body, there are potentially many variables, some predictable and others not. Complications rates in dentistry are low but they do exist. Even minor procedure such as "filling" can lead to major complication that can't be foreseen. For example, a "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complications can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, fractures and other nerve problems.

I have read, understand and consent to dental treatments.

FINANCIAL POLICY

1. PATIENTS WITH INSURANCE COVERAGE:

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carries if you request us to do so. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to the treatment. If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you. In some cases, insurance carrier may pay for alternative benefits than the treatment performed. In this case you are responsible to pay for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility. **All procedure involving lab work will require 50% down payment, then the remaining 50% balance will be due at the day of final insertion.** If you are having treatment over a period of time, we appreciate your payment during the course of treatment. Our financial coordinator will assist you in arranging a payment schedule.

2. PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, MasterCard, Visa, Discover, American Express or Debit/ATM cards. We also arrange pre-payments and financing plans.

3. ALL PATIENTS:

a. Unless other arrangements have been made in advance, all copay and deductibles **must be paid** at the time of service. You may have to pay approximate payment towards the co-payment for the dental treatments. We will update your balance routinely with payments received by us from your insurance company. We may keep the credit balance, if any, towards your future treatment. It is your responsibility to request our office for a statement of accounts or a refund of your credit balance.

b. We do not accept **Credit Cards** or **Personal Checks** for charges of $20.00 or less.

c. Checks returned unpaid from the bank are subject to $30.00 service fee.

d. Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency, you will be responsible for collection and court costs along with attorney's fees.

Office Policy Concerning Scheduling Appointments

When you make an appointment, we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve right to charge for any appointment(s) broken without a 24 hours advance notice. The charge will be $35.00 for every thirty minutes of appointment time.

We welcome you to our office and want to provide you service with the best possible care. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT, FINANCIAL POLICIES AND OFFICE POLICY CONCERNING SCHEDULING APPOINTEMTS.

______________________________ ______________

Signature of Patient / Parent or Guardian, if minor **Date**