New Patient Form

Personal Information

First Name _____

Last Name _____

Today's Date _____

Birthdate _____

Social Security Number _____

Street Address _____

City/State/ZipCode _____

Home Phone Number _____

Cell Phone Number _____

Email _____

Preferred Way of Communication _____

Emergency Contact Information

First Name _____

Last Name _____

Phone Number _____

Referral

Whom may we thank for referring you? _____

Insurance Information

Responsible Party _____

Relationship to Patient _____

Birthdate of Responsible Party _____

Social Security Number of Responsible Party _____

Name of Employer _____

Insurance Company _____

Group Number _____

Member/Policy ID _____

Consent

Do you authorize benefits to be assigned to provider? _____

Do you allow release of medical data to other organizations (ex. insurance, referrals)? _____

Signature

Health History Form

Personal Information

First Name _____

Last Name _____

Birthdate _____

Name of person filling out form, if different from above: _____

Relation to patient _____

Do you have any of the following conditions?

Active Tuberculosis _____

Persistent cough for more than 3 months _____

Cough that produces blood _____

Been exposed to anyone with Tubercolosis _____

Dental Information

Do your gums bleed when you brush or floss? _____

Are your teeth sensitive to cold, hot, sweets? _____

Do you have dry mouth? _____

Have you had any periodontal (gum) treatment? _____

Have you had any orthodontic (braces) treatment? _____

Have you had any problems associated with previous dental treatment? _____

Do you have earaches or neck pains? _____

Do you have any clicking, popping, or discomfort in the jaw? _____

Do you brux or grind your teeth? _____

Do you have ulcers or sores in your mouth? _____

Do you wear dentures or partials? _____

Do you participate in active recreational activities? _____

Have you ever had serious injury to your head or mouth? _____

Are you currently experiencing dental pain or discomfort? _____

What is the reason for your dental visit today?

Date of your last dental exam _____

What was done at that visit?

Date of your last dental x-rays _____

Medical Information

Are you under the care of a primary care physician? _____

Physician Name _____

Physician Phone Number _____

Has your health changed within the past year? _____

If yes, please explain:

Date of last physical exam _____

Have you had any serious illness, surgery, or hospitalization in the past 5 years? _____

If yes, please explain:

Are you taking any prescription or over-the-counter medication? _____

If yes, please list:

Have you had an orthopedic total join (hip, knee, elbow, finger) replacement? _____

If yes, when? _____

Are you taking or scheduled to begin taking any bisphosphonates (Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's Disease? _____

Do you use tobacco products? _____

How many alcoholic drinks do you have per week? _____

Women: Are you pregnant or possibly pregnant? _____

Do you have any allergies?

Medical Conditions (Requiring Pre-Medication)

Artificial (Prosthetic) Heart Valve _____

Previous Infective Endocarditis _____

Damaged valves in transplanted hearts _____

Congenital Heart Disease: unrepaired, cyanotic _____

Congenital Heart Disease: repaired (completely) in last 6 months _____

Congenital Heart Disease: repaired with residual defects _____

Has a physician or dentist ever recommended you pre-medicate prior to dental procedures? _____

Name and Number of Physician or Dentist who made the recommendation:

Medical Conditions

Cardiovascular Disease _____
Angina _____
Arteriosclerosis _____
Congestive Heart Failure _____
Damaged Heart Valves _____
Heart Attack _____
Heart Murmur _____
Low Blood Pressure _____
High Blood Pressure _____
Other Congenital Heart Defects _____
Mitral Valve Prolapse _____
Pacemaker _____
Rheumatic Fever _____
Rheumatic Heart Disease _____
Abnormal Bleeding _____
Anemia _____
Blood Transfusion _____
If yes, what date? _____
Hemophilia _____
AIDS/HIV Infection _____
Arthritis _____
Autoimmune Disease _____
Rheumatoid Arthritis _____
Systemic Lupus _____
Asthma _____
Bronchitis _____
Emphysema _____
Sinus Infections _____
Tuberculosis _____
Cancer/Chemotherapy/Radiation Therapy _____
Chest pain upon exertion _____
Chronic Pain _____
Diabetes Type I or II _____
Gastrointestinal Disease _____
Gastric Reflux/ Persistent Heartburn _____
Hypothyroidism _____
Hyperthyroidism _____

Stroke _____

Hepatitis/Jaundice/Liver Disease _____

Epilepsy or seizures _____

Neurological Disorders _____

If yes, please specify

Sleep Disorder _____

Do you snore? _____

Mental Health Disorders _____

If yes, please specify

Kidney Disease _____

Osteoporosis _____

Sexually Transmitted Disease _____

Other

Signature

Policies

Consent for Treatment

I hereby authorize Dental Studio of Jersey City to administer and perform the necessary procedures, such as x-rays, anesthetics, and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia, and other procedure specific risks.

Insurance

I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment. I authorize Dental Studio of Jersey City to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collecition sums due and unpaid for the work herein set forth.

If any insurance changes should occur during the time I am a patient, I am responsible of informing the office. The office is not responsible for claims submitted to insurance companies by which I am no longer covered.

While the office accepts most dental insurance plans, and is happy to aid in submission of claims, it is the patient's responsibility to read their policy and be aware of services covered or not covered by their individual plans.

Financial

Patients are required to pay their deductibles and co-payments at the time of each visit.

I agree to pay my portion of the bill at the time of service.

I understand that insurance policies are a contract between me, my employer,and the insurance carrier. I am therefore ultimately responsible for payment of my account.

I understand that as a courtesy, Dental Studio of Jersey City can submit for pre-authorizations of procedures to my insurance company. All estimates however are not guarantee of payment by the insurance carrier.

Failed or Cancelled Appointments

If an appointment has been reserved for me, I understand I must give 24 hours notice for all cancellations; otherwise the office reserves the right to charge me a broken appointment fee. The office does not need to offer me appointments after multiple failed appointments without proper notice.

Notice of Privacy Practices (HIPAA)

A copy of the office's Notice of Privacy Practices is available in the office. I understand I have the right to read the notice, which describes the description of our treatment, payment activities, and healthcare operations.

Signature