Adult Patient Information

474 Hurfville-Crosskeys Road
Atrium One, Suite A - Sewell, NJ 08080
856-582-1000

Patient Information

Full Name *(last, first, middle)*: ______

SS#: ______ Driver Lic #: ______

Home #: ______ Cell #: ______ Email: ______

Home Address: ______

City: ______ State: ______ Zip: ______

Gender: ❑M ❑F Age: ______ Date of Birth: ______ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by: ______ Occupation: ______

Business Address: ______ Business Phone: ______

Full-Time Student: ❑Y ❑N Name of College: ______ City & State: ______

How did you hear about us? ❑Yellow Pages ❑ Family ❑ Other: ______

In case of emergency who should be notified? ______ Phone: ______

Primary Insurance

Person Responsible for Account *(last, first, middle)*: ______

Relationship to patient: ______ Insured's Birthdate ______ Insured's SS#: ______

Address (if different than patient): ______ Phone: ______

City: ______ State: ______ Zip: ______

Person Responsible Employed by: ______ Occupation: ______

Business Address: ______ Business Phone: ______

Insurance Company: ______

Contract #: ______ Group #: ______ Subscriber #: ______

Name of other dependents covered under this plan: ______

Additional Insurance

Patient Covered by Additional Insurance: ❑Y ❑N

Subscriber Name *(last, first, middle)*: ______

Relationship to patient: ______ Insured's Birthdate ______ Insured's SS#: ______

Address (if different than patient): ______ Phone: ______

City: ______ State: ______ Zip: ______

Subscriber Employed by: ______ Business Phone: ______

Insurance Company: ______

Contract #: ______ Group #: ______ Subscriber #: ______

Name of other dependents covered under this plan: ______

The above information is accurate and complete to the best of my knowledge. Any errors or omissions in completing this form are solely my responsibility. We reserve the right to charge for appointments cancelled or failed without 24 hours advance notice. Weekdays after 4PM and Saturdays will automatically be charged. Payment is due in full at time of treatment unless prior arrangements have been approved. **Balances unpaid after 90 days are subject to a late charge of 1.5% per month,** and may be reported to the credit bureaus at our discretion. I understand that by signing below I accept financial responsibility for all charges whether or not paid by insurance.

______ | ______

Signature of person responsible *Date*

✎ Dental History

Reason for Today's Visit: ____________________

Previous Dentists: ____________________

Address: ____________________

Date of last dental care: ____________ Date of last dental X-rays: ____________

Check (✔) any of the following that apply:

- ❑ Bad Breath
- ❑ Grinding teeth
- ❑ Sensitivity to hot
- ❑ Bleeding Gums
- ❑ Loose teeth or broken fillings
- ❑ Sensitivity to sweets
- ❑ Clicking or Popping Jaw
- ❑ Periodontal treatment
- ❑ Sensitivity when biting
- ❑ Food collection between teeth
- ❑ Sensitivity to cold
- ❑ Sores or growths in your mouth

✔ Do you like your smile? ❑Y ❑N ✔ Would you like to have whiter teeth? ❑Y ❑N

How often do you brush? ____________ How often do you Floss? ____________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Other information about your dental health or previous treatment: ____________________

✎ Medical History

Physician's Name: ____________ Date of Last Visit: ____________

Have you had any serious illnesses or operations? ❑Y ❑N If yes, please describe: ____________________

____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates: ____________

✔ (Women) Are you pregnant? ❑Y ❑N ✔ Nursing: ❑Y ❑N ✔ Taking birth control pills? ❑Y ❑N

Check (✔) any of the following that apply:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints, Pins, Screws
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone treatments
- ❑ Cough, Persistent
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Problems
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ S.T.D.
- ❑ Stroke
- ❑ Surgery
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

❑ Other: ____________________

✎ Medications

List any medications being taken: (including aspirin, contraceptives, coumadin)

____

____

____

____

Pharmacy Name: ____________________

Phone: ____________________

✎ Allergies

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Penicillin
- ❑ Sulfa
- ❑ Anesthetic
- ❑ Other: ____________________

____

The above information is accurate and complete to the best of my knowledge. Any errors or omissions in completing this form are solely my responsibility. We reserve the right to charge for appointments cancelled or failed without 24 hours advance notice. Weekdays after 4PM and Saturdays will automatically be charged. Payment is due in full at time of treatment unless prior arrangements have been approved. **Balances unpaid after 90 days are subject to a late charge of 1.5% per month,** and may be reported to the credit bureaus at our discretion. I understand that by signing below I accept financial responsibility for all charges whether or not paid by insurance.

____________________ | ____________

Signature of person responsible *Date*

HIPAA

474 Hurfville-Crosskeys Road
Atrium One, Suite A - Sewell, NJ 08080
856-582-1000

HIPAA OMNIBUS RULE - Patient acknowledgement of receipt of notice of privacy practices and consent/limited authorization & release form.
You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: ____________________

✎ The undersigned acknowledges having had full opportunity to read and consider the contents of this HIPAA Consent form and the Notice of Privacy Practices. The undersigned understands that, by signing this consent form, they are giving consent to use and disclose their protected health information to carry out treatment, payment activities, insurance and any other office procedures. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide this information with your knowledge and consent.

______________________________	______________________________
Please print patient's name	Patient Signature (if 18 or older)
______________________________	______________________________
Parent / Guardian / Legal Representative Signature	Description of Authority

☑ How do you want to be addressed when summoned from the reception area? ❑First Name Only ❑Proper Sir Name ❑Other: ____________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

☑ I AUTHORIZE contact from this office to **confirm my appointments, treatment and billing information** via:
❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Text Message My Cell Phone ❑ Email Confirmation ❑ Any of the Above

☑ I AUTHORIZE contact from this office to **information about my health** via:
❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Text Message My Cell Phone ❑ Email Confirmation ❑ Any of the Above

☑ I APPROVE being contacted about **special services, events, fund raising efforts or new heath info** on behalf of this healthcare facility via:
❑ Phone Message ❑ Text Message ❑ Email Confirmation ❑ Any of the Above ❑ None of the Above (opt out)

Your comments regarding Acknowledgement or Consents: ______________________________

____

____

Office Use Only *As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement, but did not because:*

❑ It was an emergency treatment ❑ I could not communicate with the patient
❑ The patient refused to sign ❑ The patient was unable to sign because: ____________________
❑ Other (please describe): ______________________________

Signature of Privacy Officer: ______________________________