Chart #: _
FOR OFFICE USE ONLY

Patient Information

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

Gender: _____ Family Status: _____ *Spouse's Name* _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____(ext) _____ (cell phone): _____

E-mail: _____

Address: _____ _____ _____
Street Apartment #

_____
City State Zip Code

Health Information

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

- ☐ AIDS/HIV Infection
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints, pins, or screws
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer-Type_____
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis/Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental disorders
- ☐ Mitral valve prolapse
- ☐ Nervous disorders
- ☐ Pacemaker/Defibrillator
- ☐ **Pregnancy**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Thyroid condition

OTHER:

_____
_____
_____

List any medications you are taking.

_____
_____
_____
_____
_____

Name of Primary Physician _____phone #_____Fax #_____

- Are you now under the care of a physician? ☐ 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: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

1. Have you or are you taking Fen-Phen or Redux? Yes ____No____
2. Are you taking Fosamax, Zometa or Aredia? Yes ____No____
3. Do you use Tobacco? Yes ____No____
4. Do you use controlled Substances? Yes ____No____
5. Do you have a persistent Cough or Throat Clearing not associated with an illness? Yes ____No____
6. Do you wear contact lenses? Yes ____No____

Women only

7. Are you pregnant or think you may be? Yes ____No____
8. Are you nursing? Yes ____No____
9. Are you taking oral contraceptives? Yes ____No____

Are you allergic to any of the following: PLEASE WRITE YES OR NO

1. Local Anesthetics (e.g. Novocain)? _____
2. Penicillin or any other antibiotics? _____
3. Sulfa Drugs? _____
4. Barbiturates_____
5. Sedatives_____
6. Iodine/Shellfish_____
7. Aspirin_____
8. Any Metals (nickel, mercury, etc.)_____
9. Latex or rubber_____
10. Other (please list)_____

Guarantor or Responsible Party Information

Name: _____Date of Birth_____

Social Security Number_____ Male _____Female_____ Marital Status_____

Home Address_____

Home Phone_____ Work Phone _____Cell Phone_____

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 #: _____ SS# _____

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 #: _____ SS# _____

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 and financial policy

Bella Dental Holmdel's team has fully explained to me the purpose of the procedure(s) and have also informed me of expected benefits and complications (from known and unknown causes). Attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given opportunity to ask questions and all my questions have been addressed concerning the results intended from the treatment.

I understand that during the course of treatment, unforeseen conditions may arise which necessitates procedures different from those contemplated. I, therefore, consent to the performance of additional procedures which the above named dentist or associate may consider necessary.

I understand the financial obligation attached to this procedure and agree to comply as follows:
1. Payment for all services is expected day services are rendered unless other payment arrangements have been made
2. Visa, Mastercard, American express, and Discover card are all accepted.
3. Office financing is also available through Care Credit.

Although your dental coverage does not affect your arrangement with us, our office will submit your claim forms. We will make a financial arrangement based on your ESTIMATED coverage. Please keep in mind that your insurance coverage does not dictate treatment. Our estimates are given as carefully as possible, however, your insurance carrier will ultimately decide on the benefits to be released. Any patient balance left unpaid for over 90 days will be subject to an 18% finance charge.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I ALSO UNDERSTAND THAT AS TREATEMENT PROGRESSES THE FEES DISCUSSED MAY HAVE TO BE ADJUSTED. BUT THAT I WILL BE INFORMED OF THESE ADJUSTMENTS AND HOW THEY WILL AFFECT MY PAYMENT PLAN. IN THE EVENT THAT MY PAYMENTS ARE NOT RECEIVED AS AGREED, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTION. INCLUDING BUT NOT LIMITED TO ATTORNEY FEES.
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 or payment or Responsible party

_____ Date: _____
Signature of Dentist

PATIENT DENTAL HISTORY:

Name & Location of previous Dentist _____

Date of Last Exam & Cleaning _____

Do you have or have you had any of the following: PLEASE WRITE YES OR NO

a. Pain in jaw or ears? _____
b. Pain when clenching teeth? _____
c. Bleeding, tender irritated gums _____
d. A bad taste in your mouth, or mouth odor? _____
e. Sensitivity to hot, cold, sweets, or pressure? _____
f. Headaches, ear aches, or neck pain? _____
g. Do you have a Night Guard? _____ Do you wear it? _____
h. Discolored teeth that bother you? _____
i. Are you aware of grinding or clenching of your teeth? _____
j. Do you regularly use dental floss? _____
k. Have you had any periodontal treatments? _____
l. Do you have sores in or near mouth? _____
m. Do you bite your cheeks or Lips? _____
n. Have you had difficulty with extractions? _____
o. Have you had orthodontic treatment? _____
p. Do you wear dentures or Partials? _____ If yes, date of placement _____
q. Do you like your smile? _____
r. Complications after dental treatment? _____

Referral Information

Whom may we thank for referring you to our office? _____

By signing below you are certifying that you have completed the medical and dental history to the best of your ability.

Signature of Patient, Parent or Guardian _____ Date_____

Bella Dental Holmdel

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:
Bella Dental Holmdel 668 N. BEERS ST., SUITE 203 HOLMDEL, NJ 07733 (732) 739-3070

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: _____

Privacy Authorizations:

I, _____ give my permission for the office of Bella Dental Holmdel to:

Yes _____No_____ Leave detailed message on answering machine at home relating to my dental treatment.

Yes _____No _____Leave message with a family member relating to my dental treatment.

Name Family members allowed._____

Yes _____No _____Permission to discuss my dental treatment with family members.

Name family members allowed._____

Yes _____No _____Permission to use unencrypted e-mail to communicate with you about your dental care.

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.

You May Refuse to Sign This Acknowledgement*

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

_____ _____

Signature Date