

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

By what name do you like to be called? \_\_\_\_\_

Married, Spouse's First, Last Name \_\_\_\_\_  Single  Child

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext.: \_\_\_\_\_

(Cell): \_\_\_\_\_ (E-mail) \_\_\_\_\_

Preferred contact number? \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

*Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.*

**Patient Medical History**

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV Infection    | <input type="checkbox"/> Radiation Treatment        | <input type="checkbox"/> Hepatitis/Jaundice       | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Allergies:            | <input type="checkbox"/> Growths/Tumors             | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Thyroid Problems  |
| <input type="checkbox"/> Metal/Jewelry         | <input type="checkbox"/> Chest Pains                | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Latex                 | <input type="checkbox"/> Heart Disease/Attack       | <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Dental Implant(s) |
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Glaucoma                 |  |
| <input type="checkbox"/> Penicillin            | <input type="checkbox"/> Congenital Heart Defect    | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Are You Pregnant? |
| <input type="checkbox"/> Other _____           | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Respiratory Problems     | Due Date _____                             |
| <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Tuberculosis             | OTHER: _____                               |
| <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Pacemaker                  | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> _____             |
| <input type="checkbox"/> Venereal Disease      | <input type="checkbox"/> Heart Murmur/Valve Problem | <input type="checkbox"/> Diabetes                 |  |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Mitral Valve Syndrome      | <input type="checkbox"/> Ulcers                   |  |
| <input type="checkbox"/> Cancer                |   | <input type="checkbox"/> Epilepsy/Seizures        |  |
| <input type="checkbox"/> Chemotherapy          |   | <input type="checkbox"/> Dizziness/Fainting       |  |
|  |   | <input type="checkbox"/> Sinus Problems           |  |

• Name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

Are you taking any medication(s)?  Yes  No

If yes, what medication(s) are you taking? \_\_\_\_\_

Do you use tobacco?  Yes  No

Do you use alcohol?  Yes  No  Social  Daily

Do you use Cocaine or other drugs?  Yes  No

• Have there been any changes in your dental insurance?  Yes  No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient, parent or guardian

### Patient Dental History

Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

Have you ever had any complications following dental treatment? If yes, please explain _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums bleed while brushing or flossing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain in any of your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any head, neck or jaw injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced any of the following problems in your jaw?	
a) Clicking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Pain (joint, ear, side of face)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Difficulty in opening or closing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Difficulty in chewing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any orthodontic work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you satisfied by the appearance of your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you apprehensive about having dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What type of toothbrush bristle are you using? <input type="checkbox"/> Hard <input type="checkbox"/> Medium <input type="checkbox"/> Soft	
<b>For Children:</b> Does your child have any nursing/bottle habits or thumb/finger sucking habits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

### 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 #: \_\_\_\_\_

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 #: \_\_\_\_\_

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 and Release

- I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
- I authorize the release to third party payers or health practitioners any information regarding diagnosis and treatment rendered to me or my child.
- We wish our patients to know that all professional services rendered are charged directly to the patient. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and of my dependents and that payment is due in full at the time of treatment unless prior arrangements have been approved.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- We require 48 hours notice if you cannot keep your appointment. Other patients will appreciate your courtesy in releasing this time for them. A minimum charge will be made for failed or cancelled appointments without prior notification.
- I have read the above conditions of treatment and agree to their content.

X \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of patient, parent or guardian

**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: \_\_\_\_\_

**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 is posted in our office. 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:  
Elaine M. Swingle DMD      330 Lenox Ave.      Westfield, NJ 07090      (908) 232-6132

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: **X** \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.**

**REVOCAION 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Receipt Notice of Privacy Practices**

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records at : <http://www.hhs.gov/ocr/hipaa/finalreg.html>

**You May Refuse to Sign This Acknowledgement\***

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

\_\_\_\_\_  
Signature

**For Office Use:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Communications barriers prohibited obtaining the acknowledgement
- \_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_\_\_ Other (Please Specify) \_\_\_\_\_