JASON M. SUSS D.M.D.

179 South Prospect Avenue
Bergenfield, New Jersey 07621

PATIENT INFORMATION

NAME: FIRST _____ LAST: _____ MID. INTIAL _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____ SOCIAL SECURITY#: _____

DATE OF BIRTH: _____ HOME PHONE: _____ WORK PHONE: _____

DO YOU PREFER CALLS AT ☐ HOME ☐ WORK ☐ EITHER / CELL PHONE: _____

PATIENT EMPLOYED BY: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____

IF YOU ARE A STUDENT, NAME OF SCHOOL/COLLEGE: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

SPOUSE'S INFORMATION

SPOUSE'S NAME: FIRST _____ LAST _____ MIDDLE INITIAL: _____

SPOUSE'S ADDRESS: _____

SPOUSE'S D.O.B. _____ HOME PHONE: _____ WORK PHONE: _____

SPOUSE EMPLOYED BY: _____ OCCUPATION: _____

SPOUSE EMPLOYER'S
ADDRESS _____ CITY: _____ STATE: _____

MEDICAL INFORMATION

LIST ANY DRUGS OR MEDICATIONS YOU ARE PRESENTLY TAKING: _____

_____

DATE OF YOUR LAST DENTAL VISIT: _____ ARE YOU PREGNANT? YES OR NO

ALLERGIES TO DRUGS OR ANESTHESTICS, IE PENCILLIN, NOVOCAINE: _____

_____

PLEASE ANSWER Y (YES) OR N (NO)

AIDS___
ANXIETY___
ARTIFICIAL VALVE___
ASTHMA___
CANCER___
CHEMICAL DEPENDENCY___
CIRCULATORY PROBLEM___
DIABETES___
EPILEPSY___
HEADACHES (FREQUENT)___
HEART MURMUR___
HEART PROBLEM___
HEMOPHILIA___
HEPATITIS___
HIGH BLOOD PRESSURE___
HIV POSITIVE___
JAUNDICE___
LATEX ALLERGY (BALLOONS, ETC.)___
LIVER DISEASE___
LOW BLOOD PRESSURE___
PSYCHIATRIC CARE___
RADIATION TREATMENT___
RESPIRATORY DISEASE___
RHEUMATIC FEVER___
STROKE___
ULCER___
VENEREAL DISEASE___
OTHER_____

IF ANSWERED YES TO HEART PROBLEM, PLEASE EXPLAIN:_____

_____

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER, I HAVE ANSWERED ALL THE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

PATIENT'S SIGNATURE AND DATE:_____

DO YOU HAVE INSURANCE? YES NO

******IF YES, PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY.******

PRIMARY INSURANCE INFORMATION

INSURED'S NAME:_____

RELATIONSHIP TO PATIENT:_____ **SOCIAL SECURITY #:**_____**DOB:**_____

INSURANCE COMPANY:_____

INSURANCE COMPANY'S ADDRESS:_____**CITY:**_____**STATE:**_____

INSURANCE COMPANY'S PHONE#_____**GROUP/POLICY #**_____

SECONDARY INSURANCE INFORMATION

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ **YES** ☐ **NO**

INSURED'S NAME:_____

RELATIONSHIP TO PATIENT:_____ **SOCIAL SECURITY #:**_____**DOB:**_____

INSURANCE COMPANY:_____

INSURANCE COMPANY'S ADDRESS:_____**CITY:**_____**STATE:**_____

INSURANCE COMPANY'S PHONE#_____**GROUP/POLICY #**_____

CONSENT

THE UNDERSIGNED HEREBY AUTHORIZES DR. SUSS AND STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DR. SUSS TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS.

I ALSO AUTHORIZE DR. SUSS AND STAFF TO PERFORM ALL RECOMMENDED TREATMENT MUTALLY AGREED UPON BY ME AND TO USE THE APPROPRIATE MEDICATIONS AND THERAPY INDICATED FOR SUCH TREATMENT IN CONNECTION WITH THE AFORE MENTIONED PATIENT. I UNDERSTAND THAT USING ANESTHETIC AGENTS EMBODIES A CERTAIN RISK, FURTHERMORE, I AUTHORIZE AND CONSENT THAT DR. SUSS CHOOSE AND EMPLOY SUCH ANESTHESIA AS DEEMED FIT TO PROVIDE RECOMMENDED TREATMENT.

I UNDERSTAND THAT ALL RESPONSIBILITY OF PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IN THE EVENT PAYMENTS ARE NOT RECEIVED BY THE AGREED UPON DATES, I UNDERSTAND A FINANCE CHARGE MAY BE ADDED TO MY ACCOUNT, IN ADDITION TO ALL COLLECTION FEES INCLUDING LAWYER AND COURT COSTS.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ADVISE YOUR OFFICE OF ANY CHANGES IN THE INFORMATION CONTAINED ON THIS FORM.

PATIENTS SIGNATURE:_____ **DATE:**_____

DOCTOR'S SIGNATURE:_____ **DATE:**_____

Jason Suss, D.M.D.

179 South Prospect Avenue
Bergenfield, NJ 07621

Phone: (201) 384-2880

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ **Payment by cash**

___ **Payment by check**

___ **Payment by credit card**

___ **Automatic monthly billing to your Visa or MasterCard**

___ **Guarantee any amount not covered by insurance with Visa or MasterCard.**

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

*x*_____
Date:_____

Jason M. Suss, DMD

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:
Home: Cell: 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:
Jason M. Suss, DMD 179 South Prospect Avenue Bergenfield, NJ 07621

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: _____

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.

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.
HIPAA web-site: 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.

_____ Date: _____
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)

_____
_____
_____