The Dental Center

731 Bloomfield Avenue
Bloomfield, NJ 07003
(973) 743-5116

Welcome to our office. Please fill out all forms.

TELL US ABOUT YOURSELF (PATIENT INFORMATION)

Today's Date_____ Patient's Name_____

Social Security # _____-_____-_____ Date of Birth_____

Home Address _____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Email_____

Employer_____ Business Phone (_____)_____-_____

Pharmacy _____Address_____Phone (_____)_____-_____

How did you hear about us? ☐ Referred by _____

☐ Telephone Directory ☐ Drive/ Walk By ☐ Other _____

Purpose of today's appointment? _____

_____

EMERGENCY INFORMATION

In Case of emergency, contact_____

Address _____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Work Phone (_____)_____-_____

DENTAL HISTORY

When was your last check-up?_____When was your last cleaning? _____

When was your last full set of xrays? _____

Have you ever had any abnormal bleeding associated with previous extractions, surgeries, or trauma? ☐yes ☐no

Are you aware of grinding or clenching your teeth? ☐yes ☐no

Have you had any dental anesthesia before? ☐yes ☐no

If yes, any adverse reactions? _____

Have you had instruction on the correct method of brushing your teeth and care of your gums? ☐yes ☐no

Do you have any dental complaints at this time? _____

_____

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MEDICAL HISTORY

Are you under the care of a physician? ☐yes ☐no

If yes, what condition? _____

Name of Physician _____

Address _____

Office Phone # (_____)_____-_____

Are you currently taking any medication? ☐yes ☐no

If yes, please list medications _____

_____

Do you have or have you had any of the following problems or diseases? (check if yes)

☐Heart Murmur ☐Heart Problems ☐High Blood Pressure ☐Hepatitis, Jaundice, or Liver Disease ☐AIDS
☐Any Blood Disease ☐Rheumatic Heart Fever ☐Asthma or Hay Fever ☐Veneral Disease ☐Diabetes
☐Kidney Ailment ☐Epilepsy ☐Tumors or Growths ☐Other

If yes to any of the above, explain _____

Do you have any disease, conditions, or other problems not listed that you think we should know about? ☐yes ☐no

If yes, describe _____

Are you allergic to any drugs/medications (such as penicillin, codeine, aspirin) or have a latex allergy?☐yes ☐no

If yes, what are you allergic to? _____

Are you pregnant? ☐yes ☐no

Comments: _____

_____

I hereby state that all of the above is correct and I am fully responsible for all fees incurred which are not covered by any insurance payment.

Signature of Patient (or parent/ legal guardian) _____

Date: _____

THERE MAY BE A CHARGE OF $75 PER HOUR FOR ANY MISSED APPOINTMENTS IF WE ARE NOT NOTIFIED 48 HOURS PRIOR TO YOUR APPOINTMENT TIME

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RESPONSIBLE PARTY INFORMATION

Payment is due at time of service.

Who is responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other_____

Name: _____ Phone # (_____)_____-_____

Address: _____

By which method will you settle this account ? ☐Cash ☐Credit ☐Check ☐Insurance & Copayment

INSURANCE INFORMATION

DENTAL Insurance Company _____

Phone# _____ Group# _____

Primary Subscriber's Name _____ DOB_____

Relationship to Patient _____

Primary Subscriber's Social Security # _____-_____-_____

ID#_____Employer Name_____

Complete this section **ONLY** if you have **SECONDARY** insurance:

2nd DENTAL Insurance Company _____

Phone# _____ Group# _____

Subscriber's Name _____ DOB_____

Relationship to Patient _____

Subscriber's Social Security # _____-_____-_____

ID#_____Employer Name_____

MEDICAL Insurance Company _____

Phone# _____ Group# _____

Subscriber's Name _____ DOB_____

Social Security #_____-_____-_____

ID#_____Employer Name_____

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CONSENT:

1. I authorize doctor to order x-rays, study models, photographs, or any diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I also authorize dental services deemed necessary and mutually agreed upon.
2. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself and my dependents is due and payable at the time services are rendered. In the event payments are not received, I understand that a 1 ½% finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information. I agree that in the event that this office institutes any legal proceedings with respect to amounts owed by me or my dependents for services rendered, they shall be entitled to recover all costs incurred including reasonable attorney's fees
5. I understand that it is my responsibility to advise your office of any changes to the information given on my medical history.

Patient _____ Date_____ Witness _____

Parent or Responsible Party_____ Relationship to Patient _____

INSURANCE PATIENTS ONLY:

As a courtesy to you, we will accept your insurance as full or partial payment toward your account. Prior to each visit, we will estimate the amount that your insurance plan does not cover and we would appreciate your portion being paid at the time services are rendered. If, however, your insurance company rejects any portion of your claim, you will be billed for the outstanding balance. Ultimate responsibility of payment to this office is yours.

I hereby authorize The Dental Center and its affiliates to provide any insurance company, claim administrator, and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

Patient or
Authorized Guardian's Signature_____Date_____

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HIPAA

HIPAA is a federal government regulation, which contains rules about how we can use your medical information with and without your prior permission. It also gives patients rights with respect to the privacy of their medical information. We are obligated by law to make available to you Notice of Privacy Practices, which explains our duties and your rights, and to get a written acknowledgment from you that you have received this information. It is therefore necessary for you to sign this form below and we ask your cooperation in this regard.

To learn more about HIPAA, you may visit the United States Department of Health and Human Services website at:
www.hhs.gov

I understand a copy of The Dental Center's Notice of Privacy Practice is available for my review.

Name (sign) _____

Date _____