*WELCOME TO OUR PRACTICE* *Date*_____

*Thank you for choosing our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We are dedicated to providing Happy Smiles for YOU……*

*Patient's Name:* _____ *SSI#*_____ *Sex: M/F*
*Last First Middle*

*Date of Birth:* _____ *Martial Status: Single/Married/Divorced/Widow* *E-Mail:*_____

*Home Phone:* _____ *Cell Phone:* _____ *Work Phone:* _____

*Patient Address:* _____ *City:* _____ *State:* _____ *Zip:*_____

*Whom can we thank for referring you to our office?* _____

*Other Family Members that are Patients Here.* _____

*Patient/Guardian's Employed by:* _____ *Occupation:* _____ *Insurance coverage: Y/N*

*Work Address:* _____ *Work Phone:* _____ *OK to call work: Y/N*

*Person responsible for account:* _____ *Relation to the patient: Self/Spouse/Dependent*
*Last First Middle*

*Insurance Co.* _____ *Policy#* _____ *Phone:* _____

*Subscriber's Name* _____ *Subscriber's Date of Birth*_____ *Subscriber's SSI #*_____

*Address (if different than Patients)* _____ *Home Phone:* _____

*City:* _____ *State:* _____ *Zip:*_____ *Work Phone:* _____

*Is Patient covered by additional insurance? Yes/No*

*Insurance Co.* _____ *Policy#* _____ *Phone:*_____

*Subscriber's Name* _____ *Relation to patient: Self/Spouse/Dependent*

*Address (if different from patient):* _____ *City:*_____ *State:*___ *Zip:* _____

*Subscriber's Date of Birth*_____ *Subscriber's SSI #*_____ *Employer:* _____

## Assignment & Release:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the used of same by the doctor in scientific papers or demonstrations.

I certify I have read to the consent of this form and do realize the risks and limitations involved.

Signature _____ Date_____

Patient's Name_____ Birth Date_____ **MEDICAL HISTORY**

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.**

Are you under a physician's care now? O Yes O No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:_____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:_____

Are you taking any medications, pills or drugs? O Yes O No If yes, please explain:_____

Do you take, or have taken, Phen-Fen or Redux? O Yes O No _____

Are you on a special diet? O Yes O No _____

Do you use tobacco? O Yes O No

Do you use controlled substances? O Yes O No

**Women: Are you**

☐ Pregnant/Trying to get pregnant?
☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Irregular Heartbeat | ☐ Scarlet Fever |
| ☐ Alzheimer's Disease | ☐ Cold Sores/Fever Blisters | ☐ Genital Herpes | ☐ Kidney Problems | ☐ Shingles |
| ☐ Anaphylaxis | ☐ Congenital Heart Disorder | ☐ Glaucoma | ☐ Leukemia | ☐ Sickle Cell Disease |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Liver Disease | ☐ Sinus Trouble |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Low Blood Pressure | ☐ Spina Bifida |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Heart Murmur | ☐ Lung Disease | ☐ Stomach/Intestinal Disease |
| ☐ Artificial Heart Valve | ☐ Drug Addiction | ☐ Heart Pace Maker | ☐ Mitral Valve Prolapse | ☐ Stroke |
| ☐ Artificial Joint | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Pain in Jaw Joints | ☐ Swelling of Limbs |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Psychiatric Care | ☐ Tonsillitis |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitits B or C | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Breathing Problem | ☐ Excessive Thirst | ☐ Herpes | ☐ Recent Weight Loss | ☐ Tumors or Growth |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ High Blood Pressure | ☐ Renal Dialysis | ☐ Ulcers |
| ☐ Cancer | ☐ Frequent Cough | ☐ Hives or Rash | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Chemotherapy | ☐ Frequent Diarrhea | ☐ Hypoglycemia | ☐ Rheumatism | ☐ Yellow Jaundice |

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain:_____

Comments:_____

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information, including the diagnosis and the records, of any treatment or examination rendered to my child or myself during the period of such health care to third party and/or health practioners. I authorize and request my insurance company to pay directly to Cosmetic and Family Dentistry insurance benefits otherwise paid to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependants and myself.

PATIENT SIGNATURE (parent if minor) _____ DATE:_____

We are dedicated to providing Happy Smiles for You

# PATIENT CONSENT FORM

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPPA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **Notice Of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice Of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice Of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain current copy of the **Notice Of Privacy Practices.**

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

DATE:_____

***Cosmetic & Family Dentistry***
***Jyoti Shah, D.D.S***
*646 Hermann Road*
*No. Brunswick, NJ 08902*
***732-246-8181***

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## Important Dental Insurance Information For Our Patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different insurance companies. Each company pays an insurance premium for specific coverage, which fits the company's budget. Each plan is different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

### Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Researching your dental insurance plan to advise you of benefits available to you.
3. Re-filing your insurance (if needed) a second time within 60 days.
4. Following the American Dental Association's guidelines for coding procedures and filing insurance claims.

### Our expectations of you as the owner of the policy:

1. Payments of fees not covered by your insurance plan at the time services are rendered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payments from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules called (Usual and Customary Rates) and excludes some procedures. All restrictions are based on premiums paid for insurance and not our fees or recommended treatment.
4. Taking responsibility for payment if your insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space and have your insurance card ready for us to copy for our file.

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if she so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.
I consent to the making of videotapes, photographs, and x-rays before, during and after treatment and to the use of same by the doctor in scientific papers or demonstrations.
I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

_____ _____

Signature of Patient/Insured Date