

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | |
|--|--|---|
| Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No | Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? _____ |
| | Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you brush? _____ |
| | Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Dental Registration and History



Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Do you wear contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No



Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____



Allergies

| | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |



Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Gentle Dental of Branchburg

Dr. Darren Brenner & Dr. Christopher Fears

Family, Cosmetic & Implant Dentistry

3461 US Highway 22 East
Branchburg, NJ 08876
908-203-1998
drb@darrenbrenner.com

DENTAL HISTORY

Are any family members current patients? YES NO

Name of previous dentist _____

Date of last dental visit _____ Date of last cleaning _____ Reason for changing _____

Please describe any current dental problems _____

YES NO Do you experience fear of having dental treatment performed?
- Please explain _____

YES NO Have you had any unpleasant dental experiences?
- Please explain _____

YOUR SMILE

YES NO Do you think you have a pretty smile?
 YES NO Have you had any cosmetic dentistry?
 YES NO Are your teeth crooked? YES NO Does this bother you?
 YES NO Do you have any fillings or blemishes on your teeth that look bad?
 YES NO Would you like to have whiter teeth?
 YES NO Is there anything that you feel could make your smile look better?
- Please describe _____

TOOTH ISSUES

YES NO Are your teeth sensitive to hot, cold, sweets or pressure?
 YES NO Does food regularly wedge between certain teeth?
 YES NO Do you have any areas that are hard to floss?

HEADACHES AND FACIAL PAIN

YES NO Do you have frequent headaches?
 YES NO Do you experience jaw popping or clicking upon opening or closing?
 YES NO Do your jaw or facial muscles ever get tired or sore after sleeping, stress, etc.?
 YES NO Do you experience facial muscle pain while chewing or when you wake up?

GUM ISSUES

YES NO Do your gums ever bleed when you brush or floss?
 YES NO Have your gums receded or pulled away from your teeth?
 YES NO Do you have bad tastes or bad breath?

CONSENT FOR USE, DISCLOSURE AND AUTHORIZATION FORM

Patient Name: _____

DOB: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

General Consent for Examination and Treatment

I hereby consent and authorize *Gentle Dental of Branchburg* and all staff, to perform a full dental head and neck examination and to take any necessary radiographs to help diagnose diseases of the oral cavity and underlying structures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand *Gentle Dental of Branchburg's* HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my *protected health information* (PHI). Our Notice provides a description of our treatment, payment activities, and healthcare operations.

A copy of Notice accompanies this Consent.

I understand that *Gentle Dental of Branchburg* has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, will post a new notice in the office. I may contact *Gentle Dental of Branchburg* at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. I may also access a copy on the website

www.gentledentalofbranchburg.com

Consent For Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations, including contacting specialists on your behalf.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting *Gentle Dental of Branchburg* :

- Dr Darren Brenner- 3461 Route 22 East, Branchburg, NJ 08876
- Telephone: 908-203-1998; Fax – 908-203-1448
- Email: drb@darrenbrenner.com

_____ Initial please

Disclosures to Authorized Individuals

I, or Authorized Individual (if patient is a minor) understand that *Gentle Dental of Branchburg* may release my PHI to the below listed family member, friend or other person indicated. Please be sure to list any parent and/or guardian if patient is a minor.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care-

Full Name: _____ Relationship: _____

I HEARBY AUTHORIZE GENTLE DENTAL OF BRANCHBURG TO SHARE:

- Any of my dental/medical information
- My appointment dates and times and reasons for the visits
- Medications I may be taking or prescribed
- The following information (specify): _____

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 *Gentle Dental of Branchburg*. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we recieved your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent for Electronic Correspondence

I HEARBY AUTHORIZE GENTLE DENTAL OF BRANCHBURG to contact me via the following:

- Phone call
- Email
- Text message (text message charges may apply)

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Individual (if patient is a minor) Name: _____

Relationship to patient: _____

Gentle Dental of Branchburg

Dr. Darren Brenner & Dr. Christopher Fears
3461 Rt. 22, Branchburg, NJ 08876
908-203-1998

DENTAL CONSENT FORM FOR LOCAL ANESTHESIA ADMINISTRATION

Patient Name: _____ **Date of Birth:** _____

Procedure: Administration of Local Anesthesia

What is Local Anesthesia?

Local anesthesia involves injecting a numbing agent near the treatment area to block nerve signals and prevent pain during a dental procedure.

Common Side Effects:

- Mild pain or discomfort at the injection site
 - Swelling or bruising
 - Temporary numbness
 - Minor bleeding
 - Dizziness or lightheadedness
-

Potential Risks and Complications:

Although rare, the following risks may occur:

- **Paresthesia:** This is a rare but known risk involving prolonged or altered sensation (numbness, tingling, or burning). It can occur due to nerve irritation or trauma, especially to the inferior alveolar nerve. Most cases resolve on their own, but some may last weeks, months, or be permanent.
 - **Infection** at the injection site
 - **Allergic reaction** to anesthetic agents (e.g., rash, swelling, breathing difficulty)
 - **Hematoma** (a localized collection of blood)
 - **Trismus** (difficulty opening the mouth)
-

--over--

Precautions:

- Inform your dentist of any medical conditions, allergies, or medications you are taking.
 - Alternative pain management methods may be available and can be discussed upon request.
-

Consent Statement:

I have read and understand the information above regarding local anesthesia. I have had the opportunity to ask questions and have received satisfactory answers. I understand the risks, including the possibility of paresthesia. I voluntarily give my consent for the administration of local anesthesia as part of my dental treatment.

Patient/Guardian Signature: _____

Date: _____

Witness Signature: _____

Gentle Dental of Branchburg
Insurance and Financial Policy

My staff and I believe that you deserve the best care. We will always present you with the ideal dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

****please initial each item after reading and sign on the bottom***

- Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit/insurance plans will never pay for complete dental care. It is only meant to assist you.
- We will file your insurance claim with most private care plans (plans that do not require you to select a dentist from a list). *Gentle Dental of Branchburg* is a preferred provider with many insurance plans. Because there are so many individual insurance plans, it is impossible to give you a guaranteed quote of your exact coverage at the time of service. **We may be able to estimate your portion based on the most up-to-date information we have, but it is only an estimate.** If you would like to know a more accurate insurance benefit, we will be happy to file a “pre-treatment authorization” with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment, but will give you a more accurate estimate of out-of-pocket expenses.
- It is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. **We will bill your insurance as a courtesy.** If insurance does not pay within 90 days, we reserve the right to request payment in full for services provided and you can collect monies due from the insurance company. Ultimately, you are responsible for all charges incurred in our office. If we are an in-network provider with your insurance company, we will balance bill you for any amount your insurance does not cover. For major work, such as crowns, implants, bridges and partials, we request a portion of the fee be paid at the start of treatment to cover the costs incurred from the laboratory.
- We accept Visa, MasterCard, Discover, cash and check. If you are in need of an extended financing option, we also work with Care Credit, which offers several “same as cash” terms, as well as programs with an interest-bearing revolving credit line designed to meet your treatment plan needs on approved credit.
- If you have a balance on your account, we will send you a monthly statement. **Payment in full is expected by the due date at the top of your statement, unless prior arrangements have been made.** It will show the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

- A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at the rate of 1.5% per month or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 90 days ago, and then subtracting any payments or credits applies to the account during that time.
- There is a fee (currently \$30) for any checks returned by the bank.
- If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay the lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Somerset County, New Jersey.
- In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- You will need to request in writing and pay a reasonable copying fee (currently \$25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including payment history.
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask for at least 24-hour notice to avoid a \$75/hour cancellation fee. If you do not show for your appointment or fail to give 24-hour notice for cancellation more than once in a 12-month period, we reserve the right to discontinue your care at our practice.

I agree with the above conditions

Print Name: _____ Date: _____

Patient/Parent Signature: _____

GENTLE DENTAL OF BRANCBURG

Dr. Darren Brenner & Dr. Christopher Fears
Family, Cosmetic & Implant Dentistry
3461 US Highway 22 East, Branchburg, NJ 08876
Phone: 908-203-1998 Fax: 908-203-1448

REQUEST FOR RELEASE OF DENTAL RECORDS

Date: _____

To: _____

Fax: _____

I, _____, authorize the release of my dental records and x-rays to Gentle Dental of Branchburg.

Patient Name: _____

Patient Signature: _____

Relationship to Patient: _____

Patient Address: _____

DIGITAL X-RAYS MAY BE SENT TO:
drb@darrenbrenner.com