DOWNBEACH DENTAL

DR. JOSEPH A. BERRETONE

8500 Ventnor Ave. Margate City, NJ 08402

(609)822-2453 FAX: (609)822-7240

Email: downbeachdental@gmail.com

www.downbeachdental.com

Patient's Information

Patient's Name	Email	Social Security Number
Home Address	City, State, Zip	Birthdate
Marital Status ❑Single ❑Married ❑Divorced ❑Other	Gender ❑Male ❑Female ❑Other	Cell Phone
Employer	Work Phone	Home Phone

Primary Insurance Company	ID Number	Subscriber Name (If not self)
Secondary Insurance Company	ID Number	Subscriber Name (If not self)

Primary Insurance Subscriber or Guardian's Information

If primary subscriber is different than guardian, please fill in primary subscriber's information below and check box here: ❑

Primary Subscriber or Guardian's Name	Email	Social Security Number
Home Address	City, State, Zip	Birthdate
Marital Status ❑Single ❑Married ❑Divorced ❑Other	Relationship to Patient	Cell Phone
Employer	Work Phone	Home Phone

How did you hear about our office?
If you were referred by a friend, what is their first and last name?

Patient's Dental History

Why have you come in to see us today?		
Previous Dentist	Last Visit	Date of Last Cleaning
Reason for changing dentist:		
Are you nervous about seeing a dentist? ❑Yes ❑No If yes, why?		
How often do you brush your teeth?	Do you floss? ❑Yes ❑No How often do you floss?	

Please check a box for each question below, even if the answer is 'No.'

❑Yes ❑No I take antibiotics before getting any dental work.
❑Yes ❑No I clench or grind my teeth during the day or while asleep.
❑Yes ❑No My gums bleed while brushing or flossing.
❑Yes ❑No I like my smile.
❑Yes ❑No I prefer tooth-colored fillings.
❑Yes ❑No I avoid brushing part of my mouth due to pain.
❑Yes ❑No My gums feel tender or swollen.
❑Yes ❑No I have problems eating.
❑Yes ❑No I have had orthodontics.
❑Yes ❑No I have had facial or jaw surgery.

Patient's Medical History

Do you have a history of any of the following? *Please check a box for each question below, even if the answer is 'No.'*

❑Yes ❑No Heart Disease ❑Yes ❑No Heart Murmur/Mitral Valve Prolapse ❑Yes ❑No Stroke ❑Yes ❑No Congenital Heart Lesions ❑Yes ❑No Rheumatic Fever ❑Yes ❑No Abnormal Blood Pressure ❑Yes ❑No Anemia ❑Yes ❑No Prolonged Bleeding Disorder ❑Yes ❑No Tuberculosis or Lung Disease ❑Yes ❑No Asthma ❑Yes ❑No Hay Fever ❑Yes ❑No Sinus Trouble ❑Yes ❑No Epilepsy/Seizures ❑Yes ❑No Ulcers ❑Yes ❑No Implants/Artificial Joints ❑Hip ❑Knee ❑Other ❑Yes ❑No I smoke or use tobacco. If yes, how much per day? For how many years? ❑Yes ❑No I have consumed alcohol within the last 24 hours. ❑Yes ❑No Have you ever taken Fen-Phen or Redux? ❑Yes ❑No I have had major surgery. Year: _____ Type of Operation:_____ Year: _____ Type of Operation:_____	❑Yes ❑No Liver Disease ❑Yes ❑No Jaundice ❑Yes ❑No Hepatitis Type _____ ❑Yes ❑No Diabetes ❑Yes ❑No Excessive Urination and/or Thirst ❑Yes ❑No Infectious Mononucleosis (Mono) ❑Yes ❑No Herpes ❑Yes ❑No Arthritis ❑Yes ❑No Sexually Transmitted/Venereal Disease ❑Yes ❑No Kidney Disease ❑Yes ❑No Tumor or Malignancy ❑Yes ❑No Cancer/Chemotherapy ❑Yes ❑No Radiation Treatment ❑Yes ❑No History of Drug Addiction ❑Yes ❑No AIDS ❑Yes ❑No Immune Suppressed Disorder ❑Yes ❑No Hearing Loss ❑Yes ❑No Fainting Spells ❑Yes ❑No Glaucoma ❑Yes ❑No History of Emotional or Nervous Discorders ❑Yes ❑No Are you taking birth control medication? ❑Yes ❑No Are you or could you be pregnant or nurding? ❑Yes ❑No Do you have any other medical problem or medical history NOT listed on this form? *(Please describe below.)*
Are you allergic to any of the following? ❑Yes ❑No Aspirin ❑Yes ❑No Ibuprofen ❑Yes ❑No Sulfa Drugs/Sulfites/Sulfides ❑Yes ❑No Penicillin ❑Yes ❑No Codeine ❑Yes ❑No Latex ❑Yes ❑No Metals, Plastics ❑Yes ❑No Local Anesthetics (Novocaine) ❑Yes ❑No Other Medications? Which ones?	**Please list all medications you are currently taking.** _____ _____ _____ _____ _____ _____ _____

Emergency Contact Information

Emergency Contact's Name	Emergency Contact's Phone	Relationship to Patient
Physician's Name	**Physician's** Phone	**Physician's** Location

Consent

I have answered all health questions to the best of my knowledge.
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Patient/Guardian's Signature: _____ Date: _____

OFFICE USE ONLY

Witness Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES or NO

May we leave a message on your answering machine at home or on your cell phone? YES or NO

May we discuss your medical condition with any member of your family? YES or NO

If YES, please name the members allowed:

_____

This consent was signed by:

_____ _____

Patients Name (PLEASE PRINT NAME) Date

_____

(PLEASE SIGN)

_____ _____

Witness Date

FINANCIAL POLICY

DOWNBEACH DENTAL • Dr. Joseph Berretone DMD

Patient Name: _____ Date: _____

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy.

VERIFYING INSURANCE: As a courtesy to our patients, we will verify insurance for benefits eligibility prior to the first appointment as well as any time we are notified of a change in coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ***ultimately responsible*** for knowing the terms of your plan; this includes any waiting periods for work to be performed. Any amount on your treatment plan that is not covered by your insurance, except for contractual fee discounts, is your financial responsibility.

INSURANCE INFORMATION: New insurance, as well as changes in insurance, must be provided to our office **prior** to your appointment. Accepting assignment of benefit from your insurance company is the equivalent of extending you credit; therefore we must have your Social Security Number on file. If you choose not to provide us your Social Security Number, you will be responsible for payment in full at the time services are rendered.

CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be provided to us immediately. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency.

REQUESTS FOR ADDITIONAL INFORMATION: These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your** responsibility.

PAYMENT: PAYMENT IS DUE AT TIME OF SERVICE

BALANCES: If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 60 days, your account may be assessed a finance charge of 1.5% per month. If your account is turned over to a collections agency a collection fee (currently $15.00) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus. If, for any reason, the account is litigated, the patient is responsible for all attorney and court fees.

REFUNDS: Overpayments will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been paid in full.

RETURNED CHECKS: There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card.

CANCELLATIONS/FAILED APPOINTMENTS: We require that you give our office 48 hours' notice in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $50.00 will be charged to you**; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education, training and/or marketing, ad nauseam.

Patient or Guardian Signature: _____ Date: _____

Signature of Staff Member: _____ Date: _____

Date: _____

Authorization for Release of Records

Dr. Joseph Berretone, DMD
8500 Ventnor Ave.
Margate, NJ 08402
(609) 822-2453
downbeachdental@gmail.com

Patients Name: _____ DOB: _____

I hereby authorize the release of my dental health records to be sent to:

Name of Office/Doctor: _____

Phone Number: _____

Email address: _____

Notes:

_____

_____

_____

_____

Item	History
FMX	
PAN	
BWS	
Prophy	

Purpose of records being released:

- ☐ Continuing Care
- ☐ Insurance
- ☐ Personal Copy
- ☐ Relocation
- ☐ Other_____

_____ _____

Signature of patient/guardian Date

_____ _____

Doctors Signature Date

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Cancellation/ Missed Appointment Policy

Our goal at DOWNBEACH DENTAL is to provide quality dental care in a timely manner. In order to do so, we have had to implement an appointment/ cancellation policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

Cancellation of an Appointment:

In order to be respectful of the dental needs of other patients, please be courteous and call Downbeach Dental promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require at least 48 hours (2 days) in advance. Appointments are high in demand, and your early cancellation will allow another person the opportunity to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call Downbeach Dental at 609-822-2453at least **48 hours (2 days)** prior to your scheduled appointment. If you do not reach the administration staff, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will return your call as soon as possible. Late cancellations will be considered a **"NO-SHOW".**

NO-SHOW Policy:

A **"NO-SHOW"** is missed appointment **without 48 hours (2 days) notice**. **"NO-SHOWS"** inconvenience other patients who may need access to dental care in a timely manner. A failure to present at the time of scheduled appointment without adequate notice will be recorded in the patient's chart as a "NO-SHOW" and reported to the patient's dental insurance. There will be a **$50.00 charge for the first event**. Any additional "NO-SHOW" will result in a **fee of $75.00.** Any further "NO-SHOW" appointments will result in termination of patient from the practice.

I have read the above policy completely. I agree to all the terms and understand that if I violate this policy it may result in the termination of my doctor/ patient relationship.

Patient Name (Please Print) **Date**

Patients Signature