Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ (NO YEARS EMPLOYED)

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

"DENTAL HISTORY"	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

"MEDICAL HISTORY"	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐				Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)

Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Franklin Corner Dental

Family, Cosmetic and Implant Dentistry

Paul G. Kost, D.M.D. Marc Cozzarin, D.M.D.

We would like to welcome you once again to our dental practice and explain a little about our office policies and goals. We believe through proper preventive care and regular checkups, it is highly likely that most of our patients can expect to keep all of their teeth for all of their lives.

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A dedication to your oral health care.
3. A minimization of costly reconstructive work through proper preventative care.
4. Our greatest effort to make your visits as comfortable as possible.
5. The right treatment at the right time.
6. Fees that are fair and just for the services provided.

In return, we expect from our patients:

1. Cooperation in making and keeping appointments.
   a. Failure to keep a reserved appointment may result in a $75 disappointment fee, when 48 hour notice is not given.
   b. Failure to keep more than one reserved appointment may require a deposit to re-schedule.
   c. Missing three appointments may result in termination of our patient/doctor relationship.
2. A conscientious effort toward good oral hygiene.
3. Recall visits to maintain optimum oral health.
4. A definite arrangement for the payment of fees at the time of service.

Insurance:

1. Our office accepts assignment of your dental insurance benefit, as long as you provide insurance benefit Information prior to your visit.
2. You will be responsible for your co-insurance and annual deductible at each visit.
3. You will be billed for claims remaining unpaid over 60 days by your insurance company.

We feel that the best investment anyone can make is to prevent the pain and discomfort associated with advancing oral disease, and to save the costly expenses often connected with the reconstruction of the damages that do occur through neglect. In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that at any time you have a question or are unhappy about any treatment (proposed or performed), fee for service, or attitude of our "Dental Team", please discuss it with us promptly and openly. Misunderstandings and/or lack of communication are the only obstacles to our continued friendship and professional relationship.

Again, we welcome you and look forward to a long lasting patient/doctor relationship. Please sign below to acknowledge receipt of our policies. Thank you.

Print Name:_____

Signature:_____ Date:_____

96 Franklin Corner Road, Lawrenceville, N.J. 08648

(609)896-0100
Fax (609)896-9046
www.franklincornerdental.com

FRANKLIN CORNER DENTAL ASSOCIATES
96 FRANKLIN CORNER ROAD
LAWRENCEVILLE, NEW JERSEY 08648
(609) 896-0100

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types and uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____
Relationship to patient (if signed by a personal representative of patient): _____

FRANKLIN CORNER DENTAL ASSOCIATES

Family, Cosmetic, Reconstructive & Sports Dentistry
Paul G. Kost, D.M.D Marc A. Cozzarin, D.M.D

We are committed to providing the highest level of service and as such we have recently implemented a new technology solution that will allow us to send you important, timely messages without interrupting your busy schedule.

This exciting new service gives us the ability to send text messages to the device of your choice, (your cell phone, email, pager, personal digital assistant (pda) or any other digital device). Since we send a text you do not have to answer a call. Simply read it and respond at your convenience. We think this is the best solution for reminding you of your appointments and keeping in touch.

Sending reminders to your mobile devices allows us to remind you even when you are not at home. We know that no one wants to miss appointments, but sometimes activities of the day get overwhelming for all of us and we forget. With this in mind we are excited to be able to remind you the same day of your appointment.

Please fill out the following fields to receive text messages from our office:

Name: _____ Email: _____

Cell Phone: _____ Other: _____
Pager or Personal Digital Assistant (pda)

Thanks for being such a great patient!

96 Franklin Corner Road Lawrenceville, New Jersey 08648 (609) 896-0100 Fax (609) 896-9046

FRANKLIN CORNER DENTAL
96 FRANKLIN CORNER ROAD
LAWRENCEVILLE, NEW JERSEY 08648
(609) 896-0100

Credit Card Authorization Form

I authorize Franklin Corner Dental Association to charge my credit card as detailed below:

Please keep this signature on file for any estimated patient portion due at time of service and for any unpaid balance after insurance payment.

Dated: _____

PATIENT NAME _____

RESPONSIBLE PARTY NAME _____

ZIP CODE _____

CREDIT CARD: VISA MASTER CARD AMERICAN EXPRESS DISCOVER

CARD # _____ **EXP. DATE** _____

CVV#: _____

SIGNATURE _____