A Dental Specialty Extension

Plainsboro Village Center
11 Schalks Crossing Road
Plainsboro, NJ 08536

609-750-1666

"To provide exclusive dental care by the best team of healthcare advisors, creating lasting relationships with you and your referrals and ultimately providing you 200% satisfaction." Motto: A home for all phases of dentistry serving you with compassion.

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Rane's Website

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Insurance Website ☐ Other ___________

Name of person or office referring you to our practice: ______________________________________

Patient Information

Patient Name: ____ (_______________) Date: __________
Last, First MI (Preferred Name)

Gender: __ Family Status:___ Social Security #: _______-_____-_____ E Mail Address______________________

Birth Date:____/___/______ Age:_______ School Grade:_______ Attending School:__________________

Phone (Home): (___)____-______ (Work):(____)____-_______ Ext: _______Cell:(_____)______-______

Address: ____
Street Apartment # City State Zip Code

Parent Information

Mother's Information ☐ the person responsible for payment
Name:____
Social Security #:_______-_____-_________
Work Phone:(_____)_______-____________Ext______
Cell Phone:(_____)______-____________
Employer:_____________________________________
Employer Address:______________________________
____

Father's Information ☐ the person responsible for payment
Name:____
Social Security #:_______-_____-_________
Work Phone:(_____)_______-_________Ext_____
Cell Phone:(_____)______-___________
Employer:_____________________________________
Employer Address:______________________________
____

Primary Insurance Information

Insurance Company Name:____________________________
Insured Name:______________________________________
Insured ID Number:__________________________________
Employer Group Name:_______________________________

Insurance Telephone Number:__________________
Insured Date of Birth:_____/____/__________
Insured Group Number_______________________

Secondary Insurance Information

Insurance Company Name:____________________________
Insured Name:______________________________________
Insured ID Number:__________________________________
Employer Group Name:_______________________________

Insurance Telephone Number:__________________
Insured Date of Birth:_____/____/__________
Insured Group Number_______________________

Health Information

Physician________________________ Office Phone ____________________ Date Of Last Exam __________

Your current physical health is: **Good** **Fair** **Poor**

1. Are you currently under the care of a physician? Yes No
   If yes please explain? ______________________
2. Are you taking any prescription or over the counter drugs? Yes No
   If yes list each one: __________________
3. Has the patient reached puberty?
   Girls- Has she started menstruation? Yes No
   Boys- Has his voice changed? Yes No
4. **Women:** Are you taking birth control pills? Yes No

Are you allergic to any of the following?

Aspirin Y N Dental Anesthetics Y N Any Metal Y N
Plastic Y N Erythromycin Y N Codeine Y N
Latex Y N Tetracycline Y N Penicillin Y N

Please list any other allergies that you have

____

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Arthritis
Y N Blood Transfusion
Y N Cancer/ Chemotherapy
Y N Congenital Heart Defects
Y N Diabetes
Y N Difficulty Breathing
Y N Epilepsy/Seizures/ Fainting spells
Y N Fever Blisters/Herpes
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High or Low Blood Pressure
Y N HIV+/ AIDS
Y N Hospitalized for any reason
Y N Kidney Problem
Y N Mitral valve prolapsed
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Chicken Pox
Y N Sinus Problems
Y N Tuberculosis(TB)
Y N Ulcers/ Colitis

Dental History

Why are you interested in Orthodontic treatment? ________________________________

Present Dentist: ____________________________
Dentist Address: __________________________ Last Dental Visit Date:__________________

Do you have now or ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? YES NO
Have you ever been evaluated or had orthodontic treatment before ? YES NO
Have there been any injuries to your face, mouth or chin? YES NO
Has the patient ever sucked a thumb or finger? Until what age? ________ YES NO
Do you have any speech problems ? YES NO
Have the adenoids or tonsils be removed? YES NO
Have you been informed of any missing or extra permanent teeth? YES NO
List any musical instruments you play? ______________________

I understand the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that my child may need.

I authorize the use of this signature on all insurance submissions. I authorize *Rane's Dental* **Aesthetics** to release all information necessary to secure payment of my benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

____
Parent/Guardian/ Patient signature Date

The parent or guardian who accompanies the child is responsible for payment.

HIPAA CONSENT

I give this practice /clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Please Note: If I request release of my records electronically the office uses AOL e-mail services.

Signature:________________________________ Date:_____________
Patient, parent or legal guardian
*If signed by patient representative, stat relationship to patient:*________________________

Please list name and relationship with only whom we may disclose your complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions?

Name: ________________________ Relationship__________________ Cell#_________________

Name: ________________________ Relationship__________________ Cell#_________________

I understand that the person(s)/organization(s) listed may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ I understand the above information and agree with its contents, and this will serve as the HIPAA Disclosure Form.

Patient or Guardian Signature ________________________________

Date_____________________________

RANE'S DENTAL AESTHETICS

11 Schalks Crossing Road, Plainsboro, NJ 08536
Tel: 609-750-1666 www.ranesdental.com

What we do at your initial orthodontic visit?

Consultation: $50 (Will be FREE with us).

Panoramic X-Ray: Is needed to see the teeth inside the jaw and to determine treatment. Cost is________________________

We usually recommend combining the consultation with the panoramic x-ray for better treatment planning and to save you time unless you tell us otherwise.

Payment is expected when care is rendered. Many insurance plans cover part of the orthodontic treatment. If yours does, our office will process the claims for you so as to get the maximum insurance benefits and only your copayment is due today if you're insurance applies one. Please note that the consult and x-ray have to be done before we can estimate any insurance payments for active orthodontic treatment.

Patient/ Parent Signature: ________________________

Date: _________________