New Patient Information (In office)

Patient Name:_____ Date:_____
Last First MI

By what name do you like to be called?_____

☐Married, Spouse's First, Last Name_____☐Single ☐Child

SocialSecurity #: _____ Birth Date:_____

Phone (Home):_____(Work):_____Ext::_____

(Cell):_____ (E-mail) _____

Preferred contact number? _____

Address: _____
Street Apartment #

_____
City State Zip Code

Person to contact in case of emergency_____Phone_____

Screening Questionaire

1. Have you recently experienced (Circle answer):

Fever or felt hot or feverish recently (14-21 days)	Yes	No
Having shortness of breath or other difficulties breathing	Yes	No
Do you have a cough?	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes	No

2. Any contact with any confirmed covid-19 positive patients? Yes No

Patient Medical History

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV Infection
- ☐ Allergies:
  - ☐ Metal/Jewelry
  - ☐ Latex
  - ☐ Aspirin
  - ☐ Penicillin
  - ☐ Other _____
- ☐ Psychiatric Treatment
- ☐ Nervous Disorders
- ☐ Venereal Disease
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Growths/Tumors
- ☐ Chest Pains
- ☐ Heart Disease/Attack
- ☐ High Blood Pressure
- ☐ Congenital Heart Defect
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Heart Murmur/Valve Problem
- ☐ Mitral Valve Syndrome
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Artificial Joints/Valves
- ☐ Glaucoma
- ☐ Excessive Bleeding
- ☐ Respiratory Problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Diabetes
- ☐ Ulcers
- ☐ Epilepsy/Seizures
- ☐ Dizziness/Fainting
- ☐ Sinus Problems
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Stomach Problems
- ☐ Dental Implant(s)

☐ Are You Pregnant?

Due Date _____

OTHER:

☐ _____

- Name of physician: _____ Phone:_____
  Address: _____Date of last exam: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
  Are you taking any medication(s)? ☐ Yes ☐ No
  If yes, what medication(s) are you taking? _____
  Do you use tobacco? ☐ Yes ☐ No
  Do you use alcohol? ☐ Yes ☐ No ☐ Social ☐ Daily
  Do you use Cocaine or other drugs? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date:_____
Signature of patient, parent or guardian

Patient Dental History

Date of Last Dental Visit:_____

Reason for this visit: _____

Have you ever had any complications following dental treatment? If yes, please explain _____	☐ Yes ☐ No
Do your gums bleed while brushing or flossing?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes ☐ No
Do you have pain in any of your teeth?	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No
Have you had any head, neck or jaw injuries?	☐ Yes ☐ No
Have you ever experienced any of the following problems in your jaw?	
a) Clicking?	☐ Yes ☐ No
b) Pain (joint, ear, side of face)?	☐ Yes ☐ No
c) Difficulty in opening or closing?	☐ Yes ☐ No
d) Difficulty in chewing?	☐ Yes ☐ No
Do you have frequent headaches?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No
Have you had any orthodontic work?	☐ Yes ☐ No
Are you satisfied by the appearance of your teeth?	☐ Yes ☐ No
Are you apprehensive about having dental treatment?	☐ Yes ☐ No
What type of toothbrush bristle are you using? ☐ Hard ☐ Medium ☐ Soft	
For Children: Does your child have any nursing/bottle habits or thumb/finger sucking habits?	☐ Yes ☐ No

Referral Information

Whom may we thank for referring you to our practice? _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

Consent and Release

- ❑ I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.
- ❑ I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
- ❑ I authorize the release to third party payers or health practitioners any information regarding diagnosis and treatment rendered to me or my child.
- ❑ We wish our patients to know that all professional services rendered are charged directly to the patient. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and of my dependents and that payment is due in full at the time of treatment unless prior arrangements have been approved.
- ❑ A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- ❑ We require 48 hours notice if you cannot keep your appointment. Other patients will appreciate your courtesy in releasing this time for them. A minimum charge will be made for failed or cancelled appointments without prior notification.
- ❑ I have read the above conditions of treatment and agree to their content.

X_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is posted in our office. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Elaine M. Swingle DMD 330 Lenox Ave. Westfield, NJ 07090 (908) 232-6132

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 the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature**: X**_____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records at : **http://www.hhs.gov/ocr/hipaa/finalreg.html**

You May Refuse to Sign This Acknowledgement*

I, _____ , have received acknowledgement of this office's Notice of Privacy Practices.

_____

Signature

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify) _____