WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext_____ Cell (_____) _____

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 _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext_____ Cell Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? ☐ Yes ☐ No

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type _____	☐ Yes	☐ No
Herpes	☐ Yes	☐ No

High Blood Pressure	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet/Weight Loss	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No

Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumors or Growths	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

Have you ever had or been diagnosed with:

Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints, Screws, Pins, etc.	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Are you allergic to:

Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Other _____

Please PRINT all medications now taking: _____

_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to 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 doctor 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.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. _____ (Name of Doctor Disclosing PHI) to use and/or disclose my Protected Health Information (PHI) related to _____ (Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed). The information will be used and/or disclosed for the purpose of _____ (Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed). I authorize Dr. _____ (Name of Doctor Receiving PHI) to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

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

_____ Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD

I, _____, GIVE PERMISSION FOR DR. CURCIO TO CHARGE THE REMAINING BALANCE AFTER INSURANCE PAYMENT IF I DO NOT REMIT PAYMENT WITHIN 45 DAYS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE OUTCOME OF MY INSURANCE CLAIM.

CARD TYPE _____ CARD # _____

EXP. DATE _____ ZIP CODE _____

SIGNATURE _____

PLEASE BE ADVISED OF OUR OFFICE POLICIES:

- WE ASK FOR A 24 HOUR NOTICE OF CANCELLATION TO AVOID A BROKEN APPOINTMENT FEE of $50.
- PAYMENTS PAST 45 DAYS ARE SUBJECT TO A 1.5% MONTHLY CHARGE.
- ALL ACCOUNTS SENT TO COLLECTIONS WILL INCUR AN ADMINISTRATIVE FEE OF $75.
- THERE WILL BE A $1.00 CHARGE FOR ALL NON-INSURANCE BILLING.
- I REALIZE THAT FAILURE TO KEEP THIS ACCOUNT CURRENT MAY RESULT IN THE OFFICE BEING UNABLE TO PROVIDE ADDITIONAL SERVICES EXCEPT FOR EMERGENCIES.

SIGNATURE_____

HIPPA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 2010 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have take action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

Dr. Fred Curcio
57 Mount Vernon Street
Ridgefield Park, NJ 07660

DR. FRED CURCIO

57 MOUNT VERNON STREET

RIDGEFIELD PARK, NJ 07660

(201) 440-5533

OFFICE POLICY

Due to the amount of time restorative procedures take, we will require a **NON-REFUNDABLE** deposit of $250. This deposit will be credited toward the cost of dental services rendered on the day of the appointment. We will retain the deposit **only if** the appointment is not cancelled within 48 hours.

Print Name

Date:

Signature