DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:

NAME OF INSURED:______________________________

INSURED SOC. SEC NUMBER:______________________________

INSURED DATE OF BIRTH:______________________________

EMPLOYER:______________________________

RELATIONSHIP TO THE INSURED: () SELF () SPOUSE () CHILD () OTHER

INSURANCE COMPANY:______________________________

INS CO ADDRESS:______________________________

____

INS CO PHONE #:______________________________

ID# :______________________________

GROUP # :______________________________

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SECONDARY INSURANCE

NAME OF INSURED:______________________________

INSURED SOC. SEC NUMBER:______________________________

INSURED DATE OF BIRTH:______________________________

EMPLOYER:______________________________

RELATIONSHIP TO THE INSURED: () SELF () SPOUSE () CHILD () OTHER

INSURANCE COMPANY:______________________________

INS CO ADDRESS:______________________________

____

INS CO PHONE #:______________________________

ID# :______________________________

GROUP # :______________________________
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Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex:

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

COVID-19 Screening Form ...

Patient's name:
Date: **Date:**

PREAPPOINTMENT CHECK **IN-OFFICE VISIT**

1. Have you previously been diagnosed with COVID-19, or do you think you've had/have COVID-19?

   YES ☐ NO ☐ YES ☐ NO ☐

   (If NO to question 1, skip to question 5)

2. If YES, when and how were you confirmed positive?

   ☐ I think I had it.

   ☐ I had a positive nasal swab test.

   ☐ I had a positive blood test.

   ☐ I had a positive saliva test.

   ☐ I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?

   ☐ I was diagnosed negative by a nasal swab test. How many times? How far apart?

   ☐ I show antibodies to COVID-19 with a blood test.

   ☐ My doctor said I no longer have it because I don't have any symptoms.

   ☐ I don't have any symptoms, so I don't have it.

4. If you have had COVID-19, when were you confirmed negative?

   ☐ 24 hours ago ☐ today ☐ 10 days after testing

5. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

Fever	YES ☐ NO ☐	YES ☐ NO ☐
	If fever, how did you measure it?	
Fatigue (feeling tired)	YES ☐ NO ☐	YES ☐ NO ☐
Altered or loss of taste/smell	YES ☐ NO ☐	YES ☐ NO ☐
Dry cough	YES ☐ NO ☐	YES ☐ NO ☐
Trouble breathing	YES ☐ NO ☐	YES ☐ NO ☐
Shortness of breath, difficulty breathing, chest tightness	YES ☐ NO ☐	YES ☐ NO ☐
Confusion	YES ☐ NO ☐	YES ☐ NO ☐
Blueish lips or face	YES ☐ NO ☐	YES ☐ NO ☐
Chills/repeated shaking with chills	YES ☐ NO ☐	YES ☐ NO ☐
Muscle pain	YES ☐ NO ☐	YES ☐ NO ☐
Headache or sore throat	YES ☐ NO ☐	YES ☐ NO ☐
Any other flu-like symptoms	YES ☐ NO ☐ PLEASE LIST	YES ☐ NO ☐ PLEASE LIST
GI upset or diarrhea	YES ☐ NO ☐	YES ☐ NO ☐

6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?

YES ☐ NO ☐ YES ☐ NO ☐

7. In the past 14 days have you traveled to any regions affected by COVID-19?

YES ☐ NO ☐ YES ☐ NO ☐

Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:

8. Are you over age 65? YES ☐ NO ☐ YES ☐ NO ☐

9. Do you have high blood pressure? YES ☐ NO ☐ YES ☐ NO ☐

If you have high blood pressure, is it controlled?

YES ☐ NO ☐ YES ☐ NO ☐

10. Do you have diabetes? YES ☐ NO ☐ YES ☐ NO ☐

11. Are you overweight? YES ☐ NO ☐ NO ANSWER ☐ YES ☐ NO ☐ NO ANSWER ☐

12. Do you have respiratory problems? YES ☐ NO ☐ YES ☐ NO ☐

13. Do you have any autoimmune disorders?

YES ☐ NO ☐ YES ☐ NO ☐

14. Are there any other conditions you would like to report?

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or heath care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understand that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has he opportunity to review this Notice.
The practice reserves the right to change the Notice of Private Practices.
The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will the cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____
Printed Name- Patient or Responsible Party

_____
Signature of Patient or Responsible Party Date

_____
Relationship to the patient (if other than the patient)

Witness: _____
Printed Name of Practice Representative

_____ ____/____/_____
Signature of Representative Date

Joel M. Richterman, D.D.S., P.A.
127 North Broadway
PO Box 407
Pennsville, NJ 08070
Phone: 856-678-5866
Fax: 856-678-4893

SIGNATURE ON FILE

I authorize use of this form on all insurance submissions.

I authorize release of information to all my Insurance Companies.

I authorize that I am responsible for bill.

I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Company.

I permit a copy of this authorization to be used in place of the original.

I authorize payment directly to my doctor.

My signature also applies to the dependents listed below.

SIGNATURE_____ DATE_____

Dependent's Name	Birth date	College/School

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collections in the event of default. I further understand that if payment becomes 30 days past due, delinquency charges at the annual rate of 16% will be due on delinquent amounts from the date the payment is due.

Signature_____ Date_____