VERONA CEDAR GROVE DENTAL ASSOCIATES vcgdental@me.com

756 POMPTON AVE. CEDAR GROVE, NJ 07009 (973) 239-6969

Patient Registration Form

Thank you for choosing our practice! We look forward to taking care of all your dental needs. Please fill out this form in ink only. If you have any questions regarding this form, do not hesitate to ask for assistance. We will be happy to help. PLEASE BRING COMPLETED FORM TO YOUR FIRST VISIT

(Please Print) Patient Name:_____

Date:_____ Birthdate:_____

SS#:_____

SEX: Male / Female (Marital Status: Single Married Divorced Widowed Partnered)

Spouse's Name:_____

Home Address:_____City/State/Zip:_____

Home Phone: _____ Work Phone_____

***Cell Phone:_____ *Email:_____**

OUR OFFICE OPERATES THROUGH EMAIL AND TEXTING MODULES. CELL PHONE AND EMAIL REQUIRED IN ORDER TO ACTIVATE PATIENT ACCOUNT.

If we have to speak with you, what is the best way to contact you? Home / Cell / Work

Work /Employer/ Occupation:_____

Address:_____

City/State/Zip:_____

Full Time Student (School)_____

Who may we thank for referring you?_____

RESPONSIBLE PARTY Name of person responsible for

Name:_____ Relationship:_____

Birthdate:_____ Age:_____ SS#:_____

Phone:_____

Address:_____

City/State/Zip:_____

Employer Name:_____

Work Phone:_____ *Please list an Emergency Contact not living with you

(Name/Phone):_____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name:_____

Relationship:_____ Birthdate:_____

SS#:_____ ID#:_____

Insurance Company:_____

Group #:_____ Insurance Phone#:_____
Insurance

Insurance Address:_____

Employer's Name:_____

Work Phone:_____

SECONDARY DENTAL INSURANCE INFORMATION

Do you have secondary dental insurance? YES NO Subscriber's

Name:_____

Relationship:_____ Birthdate:_____

SS#:_____ ID#:_____

Insurance Company:_____

Group #:_____ Insurance Phone#:_____

Insurance Address:_____

Employer's Name:_____

Work Phone:_____

CONFIDENTIAL

Name:_____**Age:**_____

Date:_____ **Former Dentist:**_____

City:_____ **State:**_____

Phone:_____ **May we contact them?** **YES** **NO**

Why did you leave your previous dental office?_____

What is the most important reason for your dental visit today?_____

The most important thing about your future smile and dental health is:_____

DENTAL INFORMATION

Please Share Some Dates:

Your Last Cleaning:_____

Your Last set of X-rays:_____

Your Last Dental Exam:_____

On a Scale of 1-10, with 10 being the highest rating:

How important is your dental health?

1 2 3 4 5 6 7 8 9 10

Where would you rate your *current* dental health?

1 2 3 4 5 6 7 8 9 10

Where do you *want* your dental health to be?

1 2 3 4 5 6 7 8 9 10

Circle if you have the following problems apply to you?

Sensitivity / (Hot/Cold/Sweets) / Headaches / Earaches / Neck pain /

Teeth or Fillings breaking / Bleeding / Swollen or Irritated gums

Food Collection Between Teeth / Jaw joint pain / Grinding, Clenching / Bad Breath

Loose, Tipped or Shifted teeth / Braces / Periodontal (gum) Treatment

Do you have/had any of the following? Dentures / Partials /Implants

MEDICAL INFORMATION

Physician's Name:_____

Phone:_____ Last Exam:_____

Have you been hospitalized within the last 5 years? YES NO

If yes, reason:_____

For the following, please circle *yes or no* if applicable:
Your answers are for our records only and will be confidential.

Please note that during your initial visit you will be asked some questions about your responses.

Our staff may ask additional questions regarding your health.

Anemia or Blood Disorder NO YES

Hepatitis NO YES

Any Form Arthritis, Rheumatism or Inflammatory Disease NO YES

Artificial Joint Replacement NO YES If YES Where? _____

Name and Phone # for Surgeon_____

Asthma NO YES

Kidney Disease NO YES

Abnormal Bleeding NO YES

Liver Disease (including Jaundice) NO YES

Cancer or Tumor NO YES Chemotherapy NO YES

Sore/ Enlarged Lymph Nodes Diabetes NO YES

Psychiatric Care NO YES

Emphysema or other Respiratory/ Lung Illness NO YES

Previous Biopsies Epilepsy NO YES

Radiation or Chemotherapy Treatment NO YES

Fainting or Dizzy Spells Glaucoma NO YES

Slow- Healing Mouth Sores NO Yes

Unintentional Weight Gain or Loss NO YES

Venereal Disease NO YES

H.I.V Infection AIDS or ARC NO YES

Rheumatic Fever NO YES

Heart Disease, Heart Attack, Heart Surgery NO YES

Heart Valve (artificial) or Heart Transplant NO YES

Abnormal Heart/ Previous Bacterial Endocarditis NO YES

Heart Murmur NO YES

Mitral Valve Prolapse NO YES

Stroke NO YES

Tuberculosis NO YES

Heart Stent Placed NO YES If YES When?_____

Cardiac Surgeon_____

Nervous Problems NO YES

Mitral Valve Prolapse NO YES

Stroke NO YES

Persistent NO YES

Back Problems NO Yes

Swelling of Feet or Ankles NO YES

Abnormal Blood Pressure? NO YES

Have you ever received a diagnosis of "high blood pressure"?
Greater than 115/75 YES NO

If yes, are you under a doctor's care? NO YES

Thyroid Problems NO YES

If YES do you have LOW or HIGH Thyroid?

Women: Are you pregnant? YES NO

Is there any chance you might be pregnant? YES NO

Are you a nursing mother? YES NO

Are you taking birth control? YES NO

FOR WOMEN WHO HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE NOTIFY STAFF IN PERSON BEFORE ANY X-RAYS OR MEDICATION IS ADMINISTERED.

CONFIDENTIAL

Name:_____

Age:_____ **Date:**_____

Are you taking or have you been treated with bisphoshonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? YES NO

If so, when did the treatment start:_____

Please list any medications, or dietary/herbal supplements you are currently taking and for what purpose:

_____

_____

_____

_____

Do you Pre-Medicate before dental visits?
NO
YES IF YES WHY?_____

ARE YOU TAKING ANY OF THE FOLLOWING?

Bloodthinners (Coumadin, Warfarin)
NO
YES

IF YOU HAVE ANSWERED YES: A MEDICAL CLEARANCE IS MANDATORY PRIOR TO VISIT: PLEASE NOTIFY STAFF WHO WILL TAKE CARE OF THIS FOR YOU

Tagamet (Cimetidine) or Prilosec (Omeprazole)
NO
YES

Antacids?
NO
YES

Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)
NO
YES

Diantin or Tegretol
NO
YES

Serzone (Nefazodone)
NO
YES

Barbiturates (any)
NO
YES

Diflucan (Fluconazole) or Sporonox (Itraconazole)
NO
YES

St. John's Wort or Kava-Kava
NO
YES

Biaxin (Clarithromycin)
NO
YES

Levoxl, Synthroid
NO
YES

Fen-Phen, Redux, Pondimin
NO
YES

Do you consume Grapefruits, juice, or extract
NO
YES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Local Anesthetics
NO
YES

Codeine, Valium or other sedatives
NO
YES

Penicillin or other antibiotics
NO
YES **If Yes: specify name_____**

Latex
NO
YES

Aspirin, Ibuprofen, Tylenol
NO
YES

Metals
NO
YES

Other (Please Specify)_____

Do you use any mood altering drugs other than those previously listed?
YES NO

Do you smoke? YES NO

IF YOU ARE LATEX SENSITIVE PLEASE ALSO VERBALLY NOTIFY STAFF

Certification and Assignment

To the best of my knowledge the above information is complete and correct. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I certify that I and my dependant(s), have insurance coverage with _____and assign directly to Verona Cedar Grove Dental Associates/ Dr. Wayne J. Madsen & Dr. Beth Cacossa-Madsen 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 claims. The above-named doctor and facility 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. I hereby authorize Verona Cedar Grove Dental Associates to take study models, X-rays, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Verona Cedar Grove Dental Associates to perform all forms of treatment, medication, and therapy that may be indicated; I also understand that the use of anesthetic agents embodies a certain risk.

Financial Policy

By signing below you are stating you understand the following: Payment & all insurance Co-pays are due at the time services are rendered. Our office accepts cash, personal checks, MasterCard, Visa, American Express & Discover. Our office also offers outside financing upon request and approvals please ask for further details. As a courtesy to our insured patients, we will gladly file your dental claims for services rendered. Please understand that we are only given an estimate for your dental care therefore we can only pass the estimate on to you, the patient. After your insurance pays their portion, there may still be an amount due. This amount will be your responsibility and will be sent to you in the form of a statement. Please understand that we will do our best to get your insurance to pay for all work performed by our office, however most insurance plans only pay for a portion of dental services. Please understand that if after 60 days there has been no payment made it is your responsibility to follow up with your insurance and retain payment.

Signature:_____
Date:_____ Patient, Parent, Guardian,
Doctor's
Signature:_____Date:_____

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Verona Cedar Grove Dental Associates to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

- Obtaining payment from third party payers (e.g. insurance company)

- Day-to-day healthcare operations of the practice (email/ text reminders/ confirmations of appointments via online services)

I have also been informed of and aware of a copy of your Notice of Privacy Practices, at vcgdental.com for my review, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Verona Cedar Grove Dental reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Patient Name Printed:_____

Signature:_____