MONTCLAIR PLAZA DENTAL GROUP

About You

Patient Name: _____ Today's Date: ___/___/___
First Mi. Last

Birth Date: ___/___/___ Age: _____ S.S.N: _____ Drivers License # _____ Male or Female (please circle)

Mailing Address: _____
City State Zip Code

Home #: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

E-mail Address: _____ Referred By: _____

Employer: _____ How Long: _____ Occupation: _____

Status: · Minor · Single · Married · Divorced · Separated · Widowed **(please circle one)**

Spouse's Name: _____ Birth Date: ___/___/___ Age: _____ S.S.N: _____

Work #: ( ) _____ Cell #: ( ) _____ E-mail Address: _____

Account Information

Person ultimately responsible for account

Name: _____ Relation: _____ Telephone #: _____

Billing Address: _____
City State Zip Code

Payment Method: · Cash · Check · Credit Card (please circle)

Insurance Information

Primary Dental Insurance Name: _____ Telephone # _____

Group #: _____ Insured's ID#: _____ Insured's Employer: _____

Insured's Name: _____ Date of Birth: ___/___/___ Relation: _____

Secondary Dental Insurance Name: _____ Telephone # _____

Group #: _____ Insured's ID#: _____ Insured's Employer: _____

Insured's Name: _____ Date of Birth: ___/___/___ Relation: _____

In Event of Emergency

Whom should we contact? _____ Relation: _____

Home #: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

Who is your medical Doctor? _____ Office #: ( ) _____

· We invite you to discuss with us any questions regarding our services, The best dental services are based on a friendly, mutual understanding between provider and patient.

· Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. · We bill insurance as a courtesy, but the patient is responsible for all services rendered.

· I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. · I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. · There will be a $50 charge for all appointments cancelled without 48 hours' notice.

_____ _____

Patient or Legal Guardian's Signature **Date**

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	**Date**	**Signature of Dentist**	**Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(AS 6/2009)

Image Release

I hereby give my consent for Dr. _____ to take photographs, slides and/or videotape of _____ (patient's name). I also grant permission to reproduce, print and/or publish these images, in print or electronically, for use in articles, lectures, or advertisements.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

I expressly authorize and grant a license to Dr. _____ his/her business, organization, employees, or agents for any use of the above-stated images and expressly release and discharge Dr. _____ his/her business, organization, employees, or agents from any and all potential claims for the use of the above-stated images.

Please initial:

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.

_____ I consent to the use of my photographs, slides, and/or videotape **ONLY** for laboratory use.

_____ I **DO NOT** consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to disclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization.

I release and discharge Dr. _____ his/her business, organization, employees or agents from any and all claims or actions I have or may have relating to such use and publication.

_____ _____

Patient's or Legal Guardian's/Representative's Signature Date

_____ _____

Dentist's Signature Date

PLACE A COPY IN THE PATIENT'S CHART.

[AS 11/2012]

MONTCLAIR PLAZA
DENTAL GROUP

Patient Acknowledgement of Dental Materials Fact Sheet

Patient Name: _____
(Please Print)

By signing this form, you acknowledge receiving from Claremont Dental Institute a copy **(Upon request)** of the Dental Materials Fact Sheet dated October 2001.

If you have any questions about the Dental Materials Fact Sheet, please contact the office at: (909) 920-0696.

_____ Date: _____
Patient or Legal Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____ have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Sign: _____

Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

For Office Use Only

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) _____

Office Policy

Please Read and sign at the bottom, acknowledging that you were informed of these policies. Let us know if you have any questions about our Office Policies. Thank you.

Financial Policy

Thank you for choosing ***Dental*** to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and photo ID card. It any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.
- New patients are required to pay for services in full on their first visit. If the patient is a member of an HMO/DMO plan then the co-payment is due. Patients are required to pay their deductible and co-payments are at the time of each visit.
- While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account until it is paid in full. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.
- If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that ***"This will be the final notice for payment"***. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.
- Financial options are available to all patients. Please feel free to ask one of our office personnel.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us twenty-four hours notice for cancellations; otherwise, we reserve the right to charge a minimum of $30.00 per half hour, which is currently our broken appointment fee. If the appointment is with a specialist, the minimum fee is $50.00 per half hour visits. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

Estimates and Fees

After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.

Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency.

Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. 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. We encourage you to read it carefully and completely before signing this Consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

Signature:_____ Date:_____