

Welcome To East Madison Dental!

Patient Registration Form



CONFIDENTIAL PATIENT INFORMATION:			
			Male <input type="checkbox"/> Female <input type="checkbox"/>
Last Name	First	MI	Age:
Street			
City		State	Zip
Date of Birth:	Patient's SS#:	Driver's License #:	
Telephone ☎:		Occupation: _____	
Home: ()	Please ✓ Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Work: ()			
Cell: ()			
Other: ()			
<i>Email:</i>		Which number would you preferred to be contacted at?	
When is the best time to reach you? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Anytime		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other: _____	

PRIMARY INSURANCE INFORMATION:			
			Relationship:
Last Name Of Insured		First	MI
Employer:	Insurance Phone #:		
Date of Birth:	SS# of Insured:		
Insurance Company:	Group #		
Address of Ins. Co:			
City		State	Zip

SECONDARY INSURANCE INFORMATION:			
			Relationship:
Last Name Of Insured		First	MI
Employer:	Insurance Phone #:		
Date of Birth:	SS# of Insured:		
Insurance Company:	Group #		
Address of Ins. Co:			
City		State	Zip

REFERRAL INFORMATION:
Whom May We Thank for Referring you to our practice? <input type="checkbox"/> Friend, Another Patient <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> Work <input type="checkbox"/> Dental Office <input type="checkbox"/> Relative, Another Patient <input type="checkbox"/> School <input type="checkbox"/> Internet <input type="checkbox"/> Other: _____
Name of person referring you to our practice: _____

PATIENT HEALTH INFORMATION: Please ✓ All That Apply.

∞ MEDICAL HISTORY ∞

Your Primary Physician's Name: _____

<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Hepatitis, Jaundice , Liver Trouble
<input type="checkbox"/> Depression, Nervous or Anxiety Disorders	<input type="checkbox"/> Gonorrhea, Syphilis, Herpes
<input type="checkbox"/> Facial Paralysis, Bell's Palsy	<input type="checkbox"/> Tuberculosis (self or family)
<input type="checkbox"/> Eye, Ear, Nose, Throat, Swallowing Problems	<input type="checkbox"/> AIDS or HIV Infection
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Taking medications or have taken for Osteoporosis
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Excessive Thirst or Urination, Change of Appetite
<input type="checkbox"/> Rheumatic Fever, Heart Murmur	<input type="checkbox"/> Swollen Ankles or Eyelids
<input type="checkbox"/> Mitral Valve Prolapse or Aortic Stenosis	<input type="checkbox"/> Diabetes, Family member with Diabetes
<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Kidney Diseases, Dialysis
<input type="checkbox"/> Pain or Pressure in Chest	<input type="checkbox"/> Thyroid/ Other Endocrine Problems
<input type="checkbox"/> Asthma, Breathing Disorders	<input type="checkbox"/> Dry or Burning Mouth / Skin
<input type="checkbox"/> Difficulty breathing or shortness of breath	<input type="checkbox"/> Joint Surgery / Prosthetic or Artificial Joint
<input type="checkbox"/> Stomach, Intestinal, Ulcers, Vomiting	<input type="checkbox"/> Major Operations or Any Hospitalizations
<input type="checkbox"/> Anemia / Blood Disease	<input type="checkbox"/> Allergies, Hay fever
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Cancer / Cancer Treatment
<input type="checkbox"/> Bleeding / Clotting Problems	<input type="checkbox"/> Alcohol / Drug Use
<input type="checkbox"/> Are you allergic to any medications? Or Latex?	<input type="checkbox"/> Tobacco Use

PLEASE LIST MEDICATIONS YOU ARE TAKING:

Are you healthy

WOMEN ONLY:

- Are you pregnant or think you're pregnant?
- Are you nursing?
- Are you taking birth control pills?

Doctor's Signature: _____ **Date:** _____

PATIENT HEALTH INFORMATION: Please ✓ All That Apply.

∞ DENTAL HISTORY ∞

What Brings You In Today?

Do you have any pain or swelling? If so, where.

When were your last x-rays taken? Date: _____

When did you last see a dentist?

Why did you leave your previous Dentist?

What do you want in a Dentist?

<input type="checkbox"/> Fillings / Crowns / Bridges	<input type="checkbox"/> Have you had a bad dental experience?
<input type="checkbox"/> Have you lost any fillings	<input type="checkbox"/> Do you clench or grind your teeth?
<input type="checkbox"/> Root Canals	<input type="checkbox"/> Facial muscle pain or pain around ears?
<input type="checkbox"/> Painful Teeth	<input type="checkbox"/> Do you have neck pain? Headaches?
<input type="checkbox"/> Are your teeth sensitive to cold or hot beverages?	<input type="checkbox"/> Last Hygiene Maintenance: _____
<input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Scaling / Root Planning (Deep Cleaning)
<input type="checkbox"/> Do your dentures fit well?	<input type="checkbox"/> Periodontal / Gum Surgery
<input type="checkbox"/> Are you happy with the dentures?	<input type="checkbox"/> Do your gums bleed when you brush?
<input type="checkbox"/> Do you like your smile?	<input type="checkbox"/> Have you lost any teeth?
<input type="checkbox"/> Would you like to improve your smile?	<input type="checkbox"/> Any Complications from tooth removal?
<input type="checkbox"/> Would you like to whiten your teeth?	<input type="checkbox"/> Oral Surgery / Implants / Facial Injuries
<input type="checkbox"/> Care to straighten your teeth	<input type="checkbox"/> Any lumps or bumps in your mouth?
<input type="checkbox"/> Have you ever worn braces?	<input type="checkbox"/> Food gets caught between teeth
<input type="checkbox"/> Do you have sleep apnea?	<input type="checkbox"/> How often do you brush daily? <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x
<input type="checkbox"/> Do you snore?	<input type="checkbox"/> Do you floss?

If you could easily change anything about your smile, what would it be? Please ✓ All That Apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Whiten Teeth | <input type="checkbox"/> Straighten Teeth | <input type="checkbox"/> Shape of Teeth |
| <input type="checkbox"/> Replace Missing Teeth | <input type="checkbox"/> Improving Your Smile | <input type="checkbox"/> Red or Swollen Gums |

Doctor's Signature: _____ Date: _____

Finances

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. If you have any questions concerning financial agreements, it will be our pleasure to assist you.

- ◆ Cash
- ◆ Personal Check
- ◆ Credit Card
- ◆ Visa
- ◆ Master Card
- ◆ Electronic Checks / EFT
- ◆ Care Credit

Authorization, Release, & Agreement To Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

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 or on behalf of my dependents.

Office Policies

- In the event you do not meet your commitment, a \$5.00 rebilling fee will be added to each month a statement is sent. (This may be in addition to finance charges)
- There is a fee of \$25.00 for returned checks.
- In the event the use of a collection agency is required, an additional \$50.00 will be applied for collections management.
- There is a \$50.00 charge for a missed appointment without a 48 hour notice. This fee is not covered by any of the insurances.
- I have received the East Madison Dental Privacy Policy.
- I certify I have read and understand the information above. To the best of my knowledge, the preceding questions have been accurately answered.
- Any refunds issued will be in the form of the original payment.

PLEASE DO NOT SHARE MY PERSONAL OR FINANCIAL INFORMATION WITH THE FOLLOWING:

SPOUSE PARENT(s) (Mother / Father) ADULT CHILD OTHER: _____

Signature of Patient

Or Parent if Minor: _____ Date: _____

EAST MADISON DENTAL, P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/2007), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Only upon your explicit instructions, we will not discuss your personal health information with your immediate family.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We may use photographs of teeth without any identifying aspects of your face for marketing and demonstrating treatment options to other patients within the practice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, email or letters).

PATIENT RIGHTS ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$75 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Denise Figueroa**

Telephone: **(201) 501-8282**

Fax: **(201) 501-8380**

E-mail: **denise@emdental.com**

Address: **79 E. Madison Ave., Dumont, NJ 07628**

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