New Patient Registration Form

Patient Information

First Name: Last Name: Middle Initial:

Patient is: ◯ Policy Holder ◯ Responsible Party Preferred Name:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address:

Birth Date: Age: Social Security: Driver's License:

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired Student Status: ◯ Full Time ◯ Part Time

Occupation:

Responsible Party (If someone other than the patient)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security: Driver's License:

Responsible Party is also a Policy Holder Primary Insurance Policy Holder Secondary Insurance Policy Holder

New Patient Registration

Primary Insurance Information

Name of Subscriber:

Relationship to Patient: ◯Self ◯Spouse ◯Child ◯Other Subscriber Social Security: Subscriber Birth Date:

Employer:

Address: City: State: Zip:

Insurance Company:

Address: City: State: Zip:

Group #:

Secondary Insurance Information

Name of Subscriber:

Relationship to Patient: ◯Self ◯Spouse ◯Child ◯Other Subscriber Social Security: Subscriber Birth Date:

Employer:

Address: City: State: Zip:

Insurance Company:

Address: City: State: Zip:

Group#:

Referral Information

Whom may we thank for referring you to our practice? (check all that apply)

◯ Newspaper ◯ Dental Office ◯ Facebook ◯ Google search ◯ Postcard ◯ Angie's List ◯ EMD Letter ◯ Social Media

Other: Name of person referring you to our practice:

101 Piermont Road • Tenafly, NJ 07670 • (201) 501-8282 •
www.emdental.com

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Your physician's name: ____

Question			
Are you under a physician's care now?	◯ Yes	◯ No	If yes, please explain: ____________
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	If yes, please explain: ____________
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, please explain: ____________
Are you on a special diet?	◯ Yes	◯ No	If yes, please explain: ____________
Do you use tobacco?	◯ Yes	◯ No	If yes, please explain: ____________
Do you use controlled substances?	◯ Yes	◯ No	If yes, please explain: ____________
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No	If yes, please explain: ____________

Women: Are You

Healthy? ◯ Yes ◯ No Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking Oral Contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Allergies:

Are you allergic to any of the following: ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics ◯ Other: __________

If yes, please explain: ____

Do you have, or have you had, any of the following:

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	☐Yes ☐ No	Cortisone Medicine	☐Yes ☐ No	Heart Trouble/Disease	☐Yes ☐ No	Reflux	☐Yes ☐ No
Alzheimer's Disease	☐Yes ☐ No	Depression	☐Yes ☐ No	Hemophilia	☐Yes ☐ No	Renal Dialysis	☐Yes ☐ No
Anaphylaxis	☐Yes ☐ No	Diabetes	☐Yes ☐ No	Hepatitis A, B or C	☐Yes ☐ No	Rheumatic Fever	☐Yes ☐ No
Anemia	☐Yes ☐ No	Drug Addiction	☐Yes ☐ No	Herpes	☐Yes ☐ No	Rheumatism	☐Yes ☐ No
Angina	☐Yes ☐ No	Dry Mouth/Skin	☐Yes ☐ No	High Blood Pressure	☐Yes ☐ No	Scarlet Fever	☐Yes ☐ No
Anxiety	☐Yes ☐ No	Easily Winded	☐Yes ☐ No	Hives or Rash	☐Yes ☐ No	Shingles	☐Yes ☐ No
Arthritis/Gout	☐Yes ☐ No	Emphysema	☐Yes ☐ No	Hypoglycemia	☐Yes ☐ No	Sickle Cell Disease	☐Yes ☐ No
Artificial Heart Valve	☐Yes ☐ No	Epilepsy or Seizures	☐Yes ☐ No	Irregular Heartbeat	☐Yes ☐ No	Sinus Trouble	☐Yes ☐ No
Artificial Joint	☐Yes ☐ No	Excessive Bleeding	☐Yes ☐ No	Kidney Problems	☐Yes ☐ No	Spina Bifida	☐Yes ☐ No
Asthma	☐Yes ☐ No	Excessive Thirst	☐Yes ☐ No	Leukemia	☐Yes ☐ No	Stomach/Intestinal Disease	☐Yes ☐ No
Blood Disease	☐Yes ☐ No	Fainting Spells/Dizziness	☐Yes ☐ No	Liver Disease	☐Yes ☐ No	Stroke	☐Yes ☐ No
Blood Transfusion	☐Yes ☐ No	Frequent Cough	☐Yes ☐ No	Low Blood Pressure	☐Yes ☐ No	Swelling of Limbs	☐Yes ☐ No
Breathing Problem	☐Yes ☐ No	Frequent Diarrhea	☐Yes ☐ No	Lung Disease	☐Yes ☐ No	Thyroid Disease	☐Yes ☐ No
Bruise Easily	☐Yes ☐ No	Frequent Headaches	☐Yes ☐ No	Mitral Valve Prolapse	☐Yes ☐ No	Tonsillitis	☐Yes ☐ No
Cancer	☐Yes ☐ No	Genital Herpes	☐Yes ☐ No	Osteoporosis	☐Yes ☐ No	Tuberculosis	☐Yes ☐ No
Chemotherapy	☐Yes ☐ No	Glaucoma	☐Yes ☐ No	Pain in Jaw Joints	☐Yes ☐ No	Tumors or Growths	☐Yes ☐ No
Chest Pains	☐Yes ☐ No	Hay Fever	☐Yes ☐ No	Parathyroid Disease	☐Yes ☐ No	Ulcers	☐Yes ☐ No
Cold Sores/Fever	☐Yes ☐ No	Heart Attack/Failure	☐Yes ☐ No	Psychiatric Care	☐Yes ☐ No	Venereal Disease	☐Yes ☐ No
Congenital Heart	☐Yes ☐ No	Heart Murmur	☐Yes ☐ No	Radiation Treatments	☐Yes ☐ No	Yellow Jaundice	☐Yes ☐ No
Convulsions	☐Yes ☐ No	Heart Pace Maker	☐Yes ☐ No	Recent Weight Loss	☐Yes ☐ No	Are you healthy?	☐Yes ☐ No

Comments:

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's)
health. It is my responsibility to inform the dental office of any changes in medical status.

______________________________________ ______________
Signature of Patient, Parent, or Guardian Date

______________________________________ ______________
Signature of Doctor Date

Dental History

Patient Name________________________________ **Medical Alert**______________

What is the reason for your visit today?________________________________

____

Date of Last Dental Visit______________ **Last Dental Cleaning**______________ **Last Full Mouth X-rays**__________

What was done at your last dental visit?________________________________

Previous Dentist's Name________________________________Telephone ______________

How often do you have dental examinations? ________________________________

How often do you brush your teeth?________________________________

How often do you floss? ________________________________

Have you ever used or are you currently using topical fluoride? ◯Yes ◯No

What other dental aids do you use? (electric toothbrush, toothpick, etc.) ________________________________

Do you have any dental problems now? ◯Yes ◯No If yes, please describe:________________________________

Do you feel nervous about having dental treatment? ◯Yes ◯No If yes, please describe: ______________________

Have you ever had an upsetting dental experience? ◯Yes ◯No If yes, please describe:______________________

Have you ever been told to take a pre-medication prior to dental treatment? ◯Yes ◯No

Is there anything else about having dental treatment that you would like us to know? ◯Yes ◯No If yes, please describe: ____________

Do you or have you had any of the following?

Orthodontic treatment	☐Yes	☐ No
Oral surgery	☐Yes	☐ No
Periodontal (Gum) treatment	☐Yes	☐ No
Your teeth ground or the bite adjusted	☐Yes	☐ No
A bite plate or mouth guard	☐Yes	☐ No
Clicking or popping of the jaw	☐Yes	☐ No
Pain? (Joint, ear, side of face)	☐Yes	☐ No
No Difficulty in opening or closing the mouth	☐Yes	☐ No
Difficulty in chewing on either side of the mouth	☐Yes	☐ No
Headaches, neck aches or shoulder aches	☐Yes	☐ No
Dry mouth	☐Yes	☐ No
Wear full/partial dentures	☐Yes	☐ No
Need to chew on one side of mouth	☐Yes	☐ No
A serious injury to the mouth or head	☐Yes	☐ No

Please describe, including cause ______________________

____

____

If you could easily change anything about your smile, what would it be? Please check all that apply

◯Whiten teeth ◯Straighten teeth
◯Shape of teeth ◯Replace missing teeth
◯Improve your smile ◯Red or swollen gums

Are any of your teeth sensitive to

Hot, cold or sweets?	☐Yes	☐ No
Biting or Chewing?	☐Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐Yes	☐ No
Do you frequently get cold sores, blisters or any oral lesions?	☐Yes	☐ No
Do your gums bleed or hurt?	☐Yes	☐ No
Have your parents experienced gum disease or tooth loss?	☐Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐Yes	☐ No
Does food tend to become caught in between your teeth?	☐Yes	☐ No

Do you:

Clench or grind your teeth while awake or asleep?

Hold foreign objects with your teeth (pencils, pipe, etc.)?

Mouth breathe while awake or asleep?

Have tired jaws, especially in the morning?

Snore or have any other sleeping disorders?

Smoke/chew tobacco or use other tobacco products?

______________________ Signature of Doctor ______________ Date

Financial Agreement

Payment is due at the time of treatment. We can accept cash, checks and major credit cards. We also have a payment plan through third party financing; these plans allow you to start treatment today and spread payments over time.

Payment Options:

Please indicate below which form of payment you choose to use: (check one)

◯ Cash ◯ Personal Check ◯ Credit Card ◯ Debit Card ◯ CareCredit®/Lending Club

Authorization, Release and 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

- There is a fee of $50.00 for returned checks.
- In the event the use of a collection agency is required, an additional $50.00 will be applied for collections management.
- EMD Guarantee*: Crowns & veneers (100% 1-3 years, 50% 4-5 years) two years on fillings, two years on sealants, two years on night guards (does not cover lost night guards). *Patients must be seen a minimum of two times per year for their routine hygiene maintenance.
- Refunds: CareCredit and Lending Club refunds will be sent back to CareCredit or Lending Club. Cash, check and credit card payments will be refunded via check.
- No Show Fee: If you are unable to keep your appointment, please give us a call 48 hours prior to your appointment to reschedule. If you do not give us advanced notice, there will be a $100 No Show fee.

MY PERSONAL OR FINANCIAL INFORMATION CAN BE SHARED WITH THE FOLLOWING:

◯ SPOUSE ◯ PARENT(s)(Mother/Father) ◯ ADULT CHILD ◯ NO ONE ◯ OTHER________

_______________________________________ Signature of Patient/Responsible Party

_______________________ Date

Consents & Notice of Privacy Practices

Text Messages

I, ________________________, consent to East Madison Dental using my cell phone to (choose one or both) ○ ○ Call or Text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include area code): _________________________________

____
Signature

Date

Email Communications

I consent to receiving from East Madison Dental email communications regarding treatment, insurance, special promotions and my account. I understand that I can withdraw my consent at any time.

My email address is: ____

____
Signature

Date

Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received and reviewed a copy of this office's Notice Privacy Practices. our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: ____

____
Signature

Date

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 ☐ Emergency Situation ☐ Communications Barrier ☐ Other:______________________

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale of information, any use of information for marketing or fundraising purposes.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization

process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the bottom of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment),payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full Payment. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the bottom of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the bottom of this Notice.
- ask to see or to get copies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for copies of your records in advance. The fee is $10 for up to 10 pages and an additional $1 per page up to a maximum of $100. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get copies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the bottom of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the bottom of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the bottom of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the bottom of this Notice. You will be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a Complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the bottom of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the bottom of this Notice.

Contact Officer: **Daniel Tise**
Telephone: **(201) 501-8282** Fax: **(201) 501-8380**
E-mail: **dan@emdental.com**
Address: **101 Piermont Road, Tenafly, NJ 07670**