PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE ________________

PATIENT'S NAME ________________ DATE OF BIRTH ________
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS ________________ PHONE ________

PERSON RESPONSIBLE FOR THIS ACCOUNT ________________ PHONE ________

ADDRESS ________________

EMPLOYED BY ________________ BUSINESS PHONE ________

BUSINESS ADDRESS ________________ PATIENT'S SS# ________

DENTAL INSURANCE PLAN (IF ANY) ________________ REFERRED BY ________

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT ________________

DATE OF LAST DENTAL EXAM ________ ANY PREVIOUS MAJOR DENTAL TREATMENT: ☐ YES ☐ NO WHEN ________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long ________
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ■ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush ________
- ☐ Frequency of brushing ________
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

MEDICAL HISTORY

PHYSICIAN'S NAME ________________ DATE OF LAST PHYSICAL EXAM ________ AGE ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month ________
- ☐ Venereal disease
- ☐ Other ________

Describe any current medical treatment including drugs taken, even though not listed above ________________

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE ________________ DATE ________
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

PATIENT CONSENT FORM

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPPA),** I have a certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of **your Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have take action relying on this consent.

Patient Name: ________________________________

Signature: ____________________________________

Relationship to patient: __________________________

Date: ______________________________

Bergen Dental Professionals: Paul W. Alberg, DMD

PATIENT AND RESPONSIBLE PARTY FINANCIAL INFORMATION AGREEMENT

Date: ___________

PATIENT: ____ **AGE/DOB**_____/________

Last Name First Name MI

____

Address City St Zip Code

Phone Day: ______________ Evening: ______________ **Email:**____________________

SSN: _________________ **Driver's Lic#:**___________________

NOTE: IF THE PATIENT IS THE **RESPONSIBLE PARTY,** YOU DO NOT NEED TO FILL OUT DUPLICATE INFORMATION

RESPONSIBLE PARTY / PARENT/EMPLOYEE/INSURED____

Last Name First Name MI

SSN:______________ **Driver's License #:**__________________**Age/ DOB:**_______ /________

____

Address City St Zip Code

Phone Day:________________ **Evening:**________________ **Email:**____________________

Employer:_________________ Insurance? Yes or No

Carrier/PPO ___________________________________

By signing below, I authorize the release of this personal information to my insurance company or other interested parties, as needed. I also authorize the payment of benefits directly to Alberg Dental and I agree that the information listed is true and correct to the best of my knowledge. I further agree that should my insurance not pay for my claims within 45 days of filing, I will be responsible to pay the balance immediately and follow-up with my insurance company personally.

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SIGNATURE OF PATIENT/PRIMARY INSURED/ PARENT OR LEGAL GUARDIAN (IF A MINOR)

BERGEN DENTAL PROFESSIONAL
379 UNION STREET
HACKENSACK, NJ 07601

CANCELLATION POLICY

FOR OUR PATIENTS:

STARTING JANUARY 01, 2014 WE WILL HAVE TO ASK EVERY PATIENT TO GIVE US A CREDIT CARD NUMBER WHEN MAKING AN APPOINTMENT, THE REASON WHY IS

WE AT BERGEN DENTAL PROFESSIONAL RESPECT YOUR TIME AND RESERVE APPOINTMENTS SPECIFICALLY FOR YOU. WE UNDERSTAND THAT EMERGENCIES ARISE. HOWEVER, IF YOU NEED TO MAKE AND CHANGES OR CANCEL YOUR APPOINTMENT, YOU HAVE TO AT LEAST GIVE US A 24HR. NOTICE IN ORDER FOR US TO REPLACE ANOTHER PATIENT IN YOUR TIME SLOT. FOR ANY NON-EMERGENCY CANCELLATIONS IN LESS THAN 24 HOURS WILL BE SUBJECT TO A $50 CANCELLATION FEE. THIS WILL BE CHARGED ON YOUR CREDIT CARD.

IT IS VERY IMPORTANT TO INFORM OUR OFFICE IF YOU CANNOT KEEP YOUR APPOINTMENT. IF YOUR TIME IS VERY IMPORTANT AND SO IS THE DOCTOR'S TIME!!

______________________________ ______________

PATIENT'S SIGNATURE DATE

(I GIVE BERGEN DENTAL PROFESSIONAL PERMISSION TO CHARGE MY CREDIT CARD FOR ANY APPOINTMENTS WITHOUT A 24HR. NOTICE.)