

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

Has any member of your family ever been treated in our office?

 Yes NoWhom may we thank for referring you to our office?
_____**METHOD OF PAYMENT**

Responsible party currently has an account with this office

 Yes No Payment in full at each appointment (cash or personal check) Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

 I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

DENTAL HISTORY

Please Circle

- Do you have a specific dental problem? Describe _____ Yes No
- Do you have dental examinations on a routine basis? Last visit _____ Yes No
- Do you think you have active decay or gum disease? _____ Yes No
- Do you brush and floss on a routine basis? Discuss _____ Yes No
- Do your gums ever bleed? Discuss _____ Yes No
- Do you like your smile? Why? _____ Yes No
- Does food catch between your teeth? Any loose teeth? _____ Yes No
- Do you want to keep your remaining teeth? _____ Yes No
- Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
- Have your past experiences in a dental office always been positive? _____ Yes No
- Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
- Name of previous dentist (optional): _____
- Date of last full mouth x-rays (16 small films or panoramic): _____

MEDICAL HISTORY

- Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
- Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
- Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
- Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? Are you on a special diet? Discuss _____ Yes No
- Are you allergic to any medications or substances? Please check box below _____ Yes No
- Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____
- Females** Please check box Pregnant/trying to get pregnant Nursing Taking oral contraceptives None

Do you now have or have you ever had any of the following? Do you take any of these medicines?

Please check appropriate boxes. If yes to any of the * conditions, please call prior to your appointment — premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur or Defect*	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonates	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Methemoglobinemia	<input type="checkbox"/>	<input type="checkbox"/>	Osteonecrosis of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Aredia I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Reclast I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Zometa I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fosamax, Actonel, Boniva	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Shunt*	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis*	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Need Premedication	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily/Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos/Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken fen-phen*	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Cochlear implants	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Stent*	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>	Protease Inhibitor	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			Other _____		

- Have you ever had any other serious illness not checked above? Discuss _____ Yes No
- Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____
PATIENT SIGNATURE (PARENT OR GUARDIAN) _____ DATE _____

Reviewed by doctor _____ Date _____ BP _____ Pulse _____
History review and significant findings _____

MEDICAL UPDATES

I have read my **MEDICAL HISTORY** dated ____/____/____ and confirm that it adequately states past/present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	None	_____	_____	_____	Dr. _____
_____	None	_____	_____	_____	Dr. _____
_____	None	_____	_____	_____	Dr. _____

New Patient Checklist

- New Patient information form
- Medical / Dental history form
- Hipaa / Office Policy form
- Dental insurance information

For us to properly submit to your dental insurance carrier please provide the following information that we need to submit for payment from your carrier

- Dental Insurance carrier
- Primary Insured Name
- Primary insured Date of Birth
- Dental ID number (may be your social security number)
- Dental Insurance group number
- Dental Insurance phone number
- Dental Insurance claims mailing address

Don't forget to **bring your insurance card** so we can make a copy for your file. Thank you for having this information readily available as this will help us process claims to reduce your out of pocket expense.

**Holmdel Periodontics
and Implant Dentistry**

WAYNE A. ALDREDGE, D.M.D. / NASIM LASEMI D.M.D
Board Certified Periodontists

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Welcome to our office.

Please take a few minutes to read and review our office policy form.

We want to thank you for choosing our practice for your dental health care needs and we appreciate the opportunity to provide you with quality healthcare. Our goal is to make you aware of our office financial policies and procedures. Your clear understanding of our policies is important to our professional relationship.

CONSENT TO CARE

I wish to be treated by Holmdel Periodontics and Implant Dentistry. While I am a patient, I permit my doctor(s), the office employees, and all the persons caring for me in the ways they judge are beneficial to me. I understand that this care may include tests, examinations, and dental treatment.

MISSED/CANCELLED APPOINTMENTS

Patients are seen by appointment only. As a courtesy to our patients, we try to confirm your next appointment. A minimum of 48 hours notice is required for canceling an appointment; there is a \$75.00 missed appointment fee. Missed appointments are a cost to us, to you, and to the patient who could have used this time slot that was set-aside for you.

FINANCIAL AGREEMENT

We are doing everything possible to minimize the cost of periodontal care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service unless other arrangements have been made in advance. This includes applicable deductibles and co-payments for participating insurance companies. Co-payments are to be paid on the date of service.

If your dental insurance is with a managed care company with which we contract, we are required to follow certain rules and regulations.

These benefit packages provided by insurance companies vary from employer to employer. You need to learn the benefits in your policy and follow the rules of the policy. We will bill the insurance company with whom we participate; however, if we are not paid within 60 days you will be expected to pay the bill in full. Except as provided by contract or state law, you are responsible for all charges.

Patients with an outstanding balance must make payment arrangements prior to scheduling further appointments. If you are experiencing financial difficulty, please let us know. Often we can defray payments, set-up 3rd party financing or arrange a gradual repayment schedule.

RETURNED CHECKS

COLLECTIONS

As previously stated, all fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered overdue. We will make every effort to arrange an equitable payment schedule. However, if no effort is made to pay the balance due, the bill will be sent to a collection agency. You will be responsible for any additional collection agency fees. In this situation, the responsible person will be asked to seek periodontal care elsewhere.

I have read and understand the above financial policy of Holmdel Periodontics. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility. I agree to keep Holmdel Periodontics accurately informed of my insurance status, and to assign benefits to Holmdel Periodontics as necessary. I authorize Holmdel Periodontics to release pertinent information to my insurance company when it is requested. If it becomes necessary to forward an amount to a collection agency, I will also be responsible for the fee charged by the agency for the cost of the collection, in addition to the original amount due. This may amount to be as much as 40% of the original fee.

RELEASE OF INFORMATION

Holmdel Periodontics & Implant Dentistry may seek, release and verify all or part of the patient's dental and/or financial records to any person, corporation, or governmental agency which is or may be liable under a statute, regulation, or contract to the office, the patient, a family member, or all or part of Holmdel Periodontics & Implant Dentistry's charges.

MEDICAL-AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of dental or medical information about me to be released to the carriers for information needed for claims. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for dentists or organization to submit a claim to insurance for payment.

HIPAA

By signing this form you will consent to our use and disclosure of your health information to carry out treatment, paying activities, and healthcare operations. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, paying activities and health care options.

We welcome you to our office and thank you for your reading and understanding of our policy form.

Signature _____

Date: _____

Witness _____

Date: _____