Midjersey Smiles LLC
1447 State Route 18, Suite 6
Old Bridge, NJ 08857
Ph # : 732-727-0895

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine / Other Narcotics
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other? _____

Check, if applicable

- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia / Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma / Hay Fever
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Heart Attack / Stroke
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives / Skin Rash
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sickle Cell Disease
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently
- ☐ Y ☐ N Use of Tobacco Products
- ☐ Y ☐ N Any Type of Implants
- ☐ Y ☐ N Any Type of Transplant

☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Anemia
☐ Y ☐ N Fainting Spells / Seizures
☐ Y ☐ N Fever Blisters / Cold Sores
☐ Y ☐ N Rheumatic Heart Disease

Dental Questionnaire

Dental Questionnaire

Do your gums bleed while brushing or flossing ? _____

Date of your last cleaning _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Additional Comments _____

Medical Questionnaire

Family Physician _____

Medical Questionnaire

Phone _____

Are you currently under care of a Physician ? ☐

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ☐

If Yes, what illness or problem ? _____

Are you currently taking any medication ? ☐

If Yes, what ? _____

Women Only

Are you pregnant?	☐
If Yes, what is your due date ?	_____
Are you currently nursing ?	☐
Are you on birth control pills / fertility drugs ?	☐
Additional Comments	
Additional information	_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**

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Tel. 732-727-0895 info@midjerseysmiles.com

Fax. 732-967-6902 www.midjerseysmiles.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THIS 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 while it is in effect. This Notice takes effect 04/17/2017, 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 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 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 health care 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 connections 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 information for treatment, payment or health care 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 disclosure 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 health care or with payment for your healthcare, but only if you agree that we do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of per (including identifying or locating) a family member, your personal representative for 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 of your health information, we will provide you with an opportunity to object to such use or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information bases on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices 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.

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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, 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 practically do so. (You must make a request in writing g 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 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 $0._____ for each page, $_____ 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 por 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 suing the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right you 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 account more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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 two alternative locations. (You must make your request in writing.) Your request must specify the alternative mean or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

Amendment: You have the right to request that we amend your health information. (You 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 received this Notice on our web site or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLIANTS

If you want more information about our privacy practices or has 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 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 compliant 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: **Ruma Anand, DDS**

Telephone: **732-727-0895** Fax: **732-967-6902** E-mail: **Midjersey Smile LLC**

Address: **1447 State Route 18 Suite#6** City: **Old Bridge** State: **NJ** Zip: **08857**

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

******You may refuse to sign this acknowledgement******

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

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- Individual refused to sign _____
- Communication barriers prohibited us from obtaining the acknowledgement _____.
- An emergency situation prevented us from obtaining acknowledgement. _____
- Other (Please Specify). _____

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ATTENTION

Due to the continuation of patients not showing for their appointments, we will be assessing a fee of fifty ($50.00) to patients who do not show for their appointment or who do not provide 48 hours notice to cancel or reschedule. If unforeseen uncontrolled circumstances apply the fee may be waived.

Please print, sign and date this document in recognition that you understand and agree to this fee. Thus, any patient with any missed appointments without adequate notice will be billed with a copy of this signed and dated document.

If you have a question, please feel free to contact the Office Manager during regular business hours.

_____ _____

(Patient/Guardian Name print) (Date)

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ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- ☐ Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance form, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- ☐ We require you sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make a payment directly to our office.
- ☐ We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide the service to you.
- ☐ Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time. You will have 45 days to make payment or an interest rate of 7%, per billing cycle, will be charged to your account.
- ☐ Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- ☐ Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____

Signature of Patient/Responsible Party

_____ Date

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TEXT MESSAGE CONSENT

Appointment Reminders Consent to Receive Text Messages By signing below, I authorize Midjersey Smiles LLC to contact me by SMS text message for health-related notifications. Later phases may include appointment reminders. I understand that message/data rates may apply to messages sent by Midjersey Smiles LLC under my cell phone plan. I know that I am under no obligation to authorize Midjersey Smiles LLC to send me text messages. I may opt-out of receiving these communications at any time by calling the main line 732-727-0895 and speaking with the office Manager. I understand that text messages are not a substitute for professional or medical attention. By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

- ○ Yes, sign me up for SMS text messages!

Signed: _____
(Patient's Name)

Signed: _____
(Parent, Legal Guardian, or POA of the patient, if patient is unable to sign for him or herself)

- ○ No, I choose not to participate in SMS text messages. Reason for Decline:

_____