Patient Information

Last Name: _____ First Name: _____ MI _____

Date of Birth: _____ Social Security Number: _____ Sex: M F

Occupation: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Insurance Information

Insurance Company: _____

Group Number: _____ Policy/ID Number: _____

Name of Policy Holder: _____

Relationship: _____ Date of Birth: _____

Address (if different from above) :_____

City: _____ State: _____ Zip Code: _____

Policy Holder Social Security Number: _____

Employer's Name: _____

DENTAL of Clementon

OUR PHILOSOPHY. Our mission is to provide you with the finest dental care. We are here to serve you and to make your dental experience as pleasant as possible. We have outlined our policies below so that we can continue our successful dental health relationship, keep our fees affordable and accept a wide range of insurance policies. As our partner, we ask that you assist us by following our policies.

APPOINTMENTS ARE DESIGNED SPECIFICALLY FOR YOU

We respect your time and ask that you do the same for us. We make a special effort to provide you and your family with a comfortable experience. This involves reserving a specialized time for you and your family to received care. Should you have to change your appointment, 24 hours of notice is required in advance. With the rising costs of administering health care, these scheduled times are very expensive. **If you fail to keep your appointment WITHOUT 24 hours advance notice, you shall be responsible for a $28 fee for *each* hour missed.** Please remember that cancelled appointments mean that somebody else was unable to be seen.

DENTAL INSURANCE & PAYMENT POLICIES

Payment is expected as treatment is rendered unless alternate arrangements have been made in advance with our treatment coordinator. You, the patient, are responsible for understanding your insurance coverage. However, as a courtesy, we will estimate your insurance benefits and will file claims with your insurance company. Our insurance estimate is just that, an estimate, and is NOT A GUARENTEE OF PAYMENT OF COVERAGE. Not until we receive an explanation of benefits (EOB), will we know the final contribution fro your insurance company.

If for any response your insurance does not pay for all or part of the services rendered by Dental of Clementon, you are responsible for the balance in full. In the event that an insurance claim has not been paid within 60 days of the service date (for any reason), you agree that you are responsible for payment to our office. In either event, you agree that you will promptly (within ten days) pay charges requested after receiving the first notice from our office. In the event that additional notices or statements are required, you agree that you will be responsible for our billing charges, the costs associated with any collection activity, including the use of an attorney, and late interest on any balance at 1.5% per month. Should money be collected from the insurance company after your payment, such will be returned to you.

If you have used a third party financing program to pay for your services, you authorize the office to process any additional payments due upon receipt of any such denial or partial coverage from your insurance company.

By signing below, you agree to this and all other practice policies, including the responsibility of such for family members. Additionally, you, the patient/responsible party, agree to assign all dental benefits received by you (on behalf of yourself or responsible account) directly to the practice for payment of such account. In the event you receive payment from the insurance company, you agree to forward such to the practice.

Thank you and welcome to our practice!

_____

Patient Name (please print)

_____ _____

Signature of Patient or Responsible Party Date

Authorization and Release

I understand that I am responsible for payment services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I understand that payment is due in full at the time of treatment and Dental of Clementon will accept any participating insurance. I hereby authorize payment directly to Dental of Clementon. I understand that I am responsible for all costs of dental treatment. I hereby authorize the release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changed in my medical status and/or dental coverage. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of Patient or Responsible Party _____ Date _____

General Consent for Treatment

I give consent for myself/my child to received dental treatment deemed necessary by the providers at Dental of Clementon. The procedures include, but are not limited to: examinations, radiographs (x-rays), oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite), crowns and/or bridges, fabrication of partial or complete dentures, periodontal (gum) treatments with the use of local anesthetics.

I understand that with the use of local anesthetics there is a possible adverse reaction that can occur. This reaction may include, but is not limited to the following: fainting, rapid heart beat, light-headedness, tightness of the chest, allergic reaction, changes in pain perception and prolonged anesthesia or paresthesia, trauma to the lips and/or cheeks. There may also be complications at the site of injection that may include, but are not limited to: numbness, bruising, swelling, hematoma, and jaw pain.

I understand that the most common undesirable side effects associated with fillings are pain, sensitivity to temperature or pressure fractures of teeth or roots, tooth nerve damage, damage to other teeth, bite (occlusal) discrepancies, TMJ problems and very rare allergic reactions to filling materials. Rarely, there may be breakage or dislodgement of filling due to buildup failure of restorative material. There may be a need for root canal therapy in case of tooth nerve damage. There may be a need for more extensive restoration, such as a crown, due to additional decay or unsupported tooth structure found during preparation. I am also aware that the shade of composite restorations may change over time.

I understand that full or partial dentures are artificial, constructed of plastic, acrylic, metal and/or porcelain and that there are limitations of wearing these appliances. These limitations include, but are not limited to looseness, soreness and possible breakage. I understand that even the best of dentures may not function as well as healthy, natural teeth. I am also aware that after final insertion of a new denture, the prosthesis may still require additional follow-up appointments for further adjusting.

I understand that during the course of treatment, procedures may need to be added, expanded or changed because of conditions that were not identified during examination could be first observed during the course of treatment. The additional or expanded dental service that the Dentist determines are necessary will be discussed with me and performed with my consent. If I am sedated or under general anesthesia during the procedure, I authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest. Furthermore, at the Dentist's discretion, I may be referred to a specialist for further treatment.

I understand that I have the opportunity to discuss alternatives, risks, and costs with the Dentist and to have all my questions answered. I understand that results cannot be guaranteed.

Signature of Patient or Parent/Guardian _____ Date _____

Signature of Doctor _____ Date _____

Signature of Witness _____ Date _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ _____ _____
Last First MI

DOB: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

_____

_____

_____

_____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, acknowledge that I have received a
(Please print name)

copy of this office's Notice of Privacy Practices.

_____ _____
Signature of Patient or Parent/Guardian 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

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify below)

_____

_____

_____

_____

Supplemental Informed Consent - Waiver Relating to COVID-19

COVID-19 has been declared a pandemic by the World Health Organization. SARS-CoV-2, the novel coronavirus that causes COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, Federal, state, and local governments and health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Dental of Clementon has put in place comprehensive measures and have purchased sophisticated personal protective equipment to reduce the spread of COVID-19 and to ensure that the risk of contracting COVID-19 is minimal; however, Dental of Clementon cannot guarantee that you will not become infected with COVID-19 while receiving dental care.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 during my treatment. I understand that the risk of becoming exposed to or infected by COVID-19 may result from actions, omissions, or negligence of any individual who are, or were, present in the dental office, including but not limited to: myself, other patients, and employees of Dental of Clementon.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to me that I may experience or incur in connection with my appointment with or treatment at the dental office ("Claims.") I hereby release, covenant not to sue, discharge, and hold harmless Dental of Clementon, its employees, agents, and representatives, and other patients of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes and Claims based on the actions, omissions, or negligence of Dental of Clementon, its employees, agents, representatives and other patients.

_____

Patient's Name

_____

Signature of Patient, Parent or Authorized

_____

Date

DENTAL of Clementon