JEFFERSON FAMILY SMILES

231 Espanong Road, Lake Hopatcong, NJ 07849
973-663-4444

PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Date of Birth: _____ Social Security #: _____

E-mail: _____

Gender: _____ Select: ◊Minor ◊Single ◊Married ◊Divorced ◊Widowed ◊Separated

Referred By: _____

Last Dental Visit (Date) _____

Dental Insurance Information

Policyholder: _____ Relationship to Patient: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Employer: _____

Address of Employer: _____

City, State, Zip: _____

Insurance Company: _____

Policy ID#: _____ Group #: _____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO - IF YES, COMPLETE THE FOLLOWING:

Policyholder: _____ Relationship to Patient: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Employer: _____

Address of Employer: _____

City, State, Zip: _____

Insurance Company: _____

Policy ID#: _____ Group #: _____

CONSENT FOR TREATMENT

I agree to treatment of my (my dependent's) oral/dental health by the practitioners of Jefferson Family Smiles. Sign_____ Date _____

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FINANCIAL AGREEMENT

I acknowledge that any treatment rendered upon me or my dependent(s) incurs fees, which are my responsibility to cover. I agree to pay any payment due from me at the time of service, including insurance deductibles, copays, or any amount not covered by dental insurance. If I have dental insurance, I must provide this office with the correct information so that it can be processed in a timely manner. It is my responsibility to ascertain whether or not I am covered by dental insurance at the time of service. Balances incurred due to non-coverage are in no way the responsibility of this dental office. Any payment due from me must be paid in full at the time of service or within 30 days of receiving a statement. If full payment cannot be made, I will be directed to apply for a line of no-interest or low-interest funding through Care Credit. In some cases, a payment plan can be set up directly through this dental office, to satisfy the debt within 6 months. I should seek out these solutions before my debt becomes delinquent for more than 30 days. This dental office is under contract with a collection agency, which will take charge of collecting delinquent debts.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees (i.e., my statement is sent out sometime later rather than immediately) I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

Print Name: _____
Responsible Party

Signed: _____

_____
Date

HEALTH HISTORY

JEFFERSON FAMILY SMILES

Patient's Name ____ Date of Birth ____ Height ____ Weight ____ Date ____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam ____________________
4. Are you now under a physician's care for A particular problem? .... Y N
5. Have you **ever** had any serious illnesses, Operations or hospitalizations? .... Y N
   If so, describe ____________________________________
   ____
6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease: .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing? .... Y N
   - E. Seizures, convulsions, Epilepsy, Fainting or Dizziness? .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Osteoporosis? .... Y N
   - O. Implants places anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - P. Radiation (X-ray) treatment for Cancer? .... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, Difficulty opening mouth, grind or clench teeth? .... Y N
   - R. Sinus or Nasal problems? .... Y N
   - S. Any disease, drug or transplant operation That has depressed your immune system? .... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (blood thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .... Y N
   - D. High blood pressure medications? .... Y N
   - E. Steroids (Cortisone, Prednisone, etc)? .... Y N
   - F. Tranquilizers? .... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drugs? .... Y N
   - I. Are you taking or ***have you ever taken*** Biosphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? .... Y N
   - J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: ____________________________________
     ____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacaine, etc)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or rubber products? .... Y N
   - G. Metal of any kind? .... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? .... Y N
   - I. Food products? .... Y N
   - J. Other allergies or reactions? Please list .... Y N
     ____
     ____
9. Do you smoke or chew tobacco? .... Y N
   How much per day? ____________________
10. Is there any past history or Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
11. Have you had any serious problems associated with any dental treatment? .... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
14. Do you wish to talk to the doctor privately about anything? .... Y N
15. Have you ever had a bone density scan? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? .... Y N
    - B. Are you nursing? .... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

______________________ ______________________________ ______________________

Date — Signature of Person Completing Health History — Doctor's Initials

- -

I have updated my medical history and indicated any changes or new findings.

______________________ ______________________________ ______________________

Date — Signature of Person Completing Health History — Doctor's Initials

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (print name)_____, have been offered a copy of

Jefferson Family Smiles' Notice of Privacy Practices.

_____ Signature (or legal guardian if minor)

_____Date

List names of people with whom Jefferson Family Smiles may discuss your health information:

Name Relationship to Patient

_____

_____

_____

May we leave voice messages regarding your health care and account? Y / N

Preferred Contact # _____