Little Falls Dental

# PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely.

## PERSONAL

Name _____
LAST FIRST MI (PREFERRED)

Birthdate _____ SS#: ___-___-____ Gender [ ] M [ ] F Marital Status M S D W Age:_____

Address_____ APT. # _____

City_____ State_____ Zip_____

Cell Phone # (____)____-____ Home Phone# (____)____-____ Work Phone # (____)____-____

Employer _____ Employer Address_____

Email _____

Preferred contact method for confirmation Home Phone [ ] Cell Phone [ ] Work Phone [ ]

Permission to leave appointment info./fees with family member YES ☐ NO ☐

Permission to leave appointment info/ fees on voicemail YES ☐ NO ☐

Student Status (if applicable) [ ] Non student [ ] Full-Time [ ] Part-Time

**If option becomes available, would you like email or text for confirmation** YES ☐ NO ☐

## INSURANCE POLICY 1 (Primary)

Your relationship to subscriber**(insurance holder)** [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID #_____

Insurance Company Name_____ Local # or Group #_____

Employer_____ [ ] Full-Time [ ] Part-Time Department:_____

Subscriber SS# ___-___-____ Subscribers Birthdate _____

***In the event that you fail to disclose any other insurance, source or plan for payment, you may be disqualified for receiving any benefits under this plan. If no secondary dental benefits, please sign here** ✖ _____

## INSURANCE POLICY 2 (Secondary) (if applicable)

Your relationship to subscriber **(insurance holder)**: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company Name _____ Local # or Group #_____

Employer _____ [ ] Full-Time [ ] Part-Time Department _____

Subscriber SS# ___-___-____ Subscribers Birthdate _____

✖ _____ _____ _____

**Patient Signature** (or signature of parent/legal guardian)

**Please Print name and relationship to patient** (if signed by a personal representative of the patient

**Date**

Little Falls Dental

# MEDICAL HISTORY

Patient Name_____Birthdate_____Today's Date_____

Name of MedicalDoctor_____City/State/Zip_____

Doctor's # (_____) _____-_____ Emergency contact_____ Phone # (_____)_____-_____

Relationship: _____

**Are you under a physician's care now?** YES ☐ NO ☐ If yes, please explain_____

***Please check yes or no to the ones that apply to you and your medical history***

Are you taking blood thinners? YES ☐ NO ☐ If yes, name of prescription _____

Have you had any artificial joint replacement YES ☐ NO ☐ If yes, date_____

Have you had any cardiac surgeries/procedures i.e., stent, valve replacement, pacemaker YES ☐ NO ☐ Specify_____

Have you been hospitalized? YES ☐ NO ☐ If yes, date_____Reason?_____

Have you undergone radiation or IV chemotherapy? YES ☐ NO ☐ Date_____ Reason _____

Have you ever needed to take antibiotics 1 hour prior to dental work? YES ☐ NO ☐

Have you ever taken Fosamax/Boniva or any medications containing bisphosphonates? YES ☐ NO ☐ If yes, dates_____

Do you smoke YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐ If yes, which trimester? _____

***Do you have, or have you had, any of the following?***

- ☐ Asthma
- ☐ Anaphylaxis
- ☐ AIDS/HIV Positive
- ☐ Abnormal Blood Pressure ( H / L )
- ☐ Heart Disease
- ☐ Heart attack / Failure / AFIB
- ☐ Stroke
- ☐ Diabetes ( Type 1 / Type 2)
- ☐ Mitral Valve Prolapse (MVP)
- ☐ Epilepsy or Seizures
- ☐ Prolonged Cough
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Shingles
- ☐ Anemia
- ☐ Cancer
- ☐ Prolonged Bleeding
- ☐ Hepatitis A, B or C. Please specify_____
- ☐ Dizziness/ Loss of Balance/ Vertigo
- ☐ Alzheimer's Disease
- ☐ Psychiatric Treatment
- ☐ Jaundice
- ☐ Stomach trouble/Ulcers/Bleeding Ulcer
- ☐ Cholesterol
- ☐ Tuberculosis or Lung Disease
- ☐ Latex allergy

***Have you ever had any serious illness NOT listed above?** YES ☐ NO ☐ If yes, explain_____

***Do you have allergies to any medications(s)?** YES ☐ NO ☐ If YES, please list_____

***List of medications you are currently taking with dosage (or provide separate list)***

_____

_____

_____

I understand and agree that, regardless of my insurance status, I am responsible for any and all fees incurred for professional services rendered by Dental Delivery Systems on my behalf. I certify that all of the information I have provided on this form is true and correct, and agree to notify you any changes regarding the above information. I also understand that payment is due in full on the date of service or my account will be considered past due. If I fail to adhere to this policy, my account will be subject to a $15.00 service charge 45 days from the date of service. After 90 days, I understand and agree that my account may be referred for collection. If this occurs, I will be responsible for the unpaid balance, and additional $15.00 service fee, plus an additional 25% of the unpaid balance or a minimum of $25.00. A broken appointment fee will be charged for any "no shows" and appointments not canceled at least 24 hours prior to the appointment.

✖_____ **Patient Signature** (or signature of parent/legal guardian)

_____ **Please Print name and relationship to patient** (if signed by a personal representative of the patient)

_____ **Date**

Little Falls Dental

## MEDICAL INSURANCE (Primary)

Your relationship to subscriber(**insurance holder**) [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID #_____

Insurance Company Name_____ Local # or Group #_____

Employer_____ [ ] Full-Time [ ] Part-Time Department:_____

Subscriber SS# _____-_____-_____ Subscribers Birthdate _____

***In the event that you fail to disclose any other insurance, source or plan for payment, you may be disqualified for receiving any benefits under this plan. If no secondary medical benefits, please sign here** X _____

## MEDICAL INSURANCE (Secondary) (if applicable)

Your relationship to subscriber **(insurance holder)**: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company Name _____ Local # or Group #_____

Employer _____ [ ] Full-Time [ ] Part-Time Department _____

Subscriber SS# _____-_____-_____ Subscribers Birthdate _____

# DENTAL HISTORY

**Patient Name:** _____ **Birthdate:** _____ **Todays Date:**_____

Name of previous dentist_____ Last Dental Visit _____ Reason for today's visit _____

Have you ever had a serious problem associated with a previous dental treatment? YES ☐ NO ☐

If **"YES"** please explain _____

How often do you brush? _____ How often do you floss?_____ How often do you get cleanings?_____

What dental aids do you use? [ ] Floss [ ] Toothpick [ ] Water Pik [ ] Electric/Sonicare Toothbrush [ ] Other_____

Do you smoke? YES ☐ NO ☐ If **yes**, how much_____ For how long?_____

**What do you NOT like about your smile?** _____

**What can we do to make your smile better?** _____

_____

Little Falls Dental

## LITTLE FALLS DENTAL OFFICE POLICY

Your dental coverage is a contract between you, the patient, and your insurance company or dental benefits provider – not the dentist. It is your responsibility to understand your dental coverage, as you are ultimately responsible for all fees incurred. Questions regarding your dental coverage should be directed to your insurance company or dental benefits provider.

Co-payments, co-insurance and deductibles are the patient's responsibility and are due immediately. If you have any questions or concerns regarding these, please ask prior to treatment. Additionally, it is your responsibility to be aware of your annual dental maximum, as you will be responsible for any fees that exceed it.

It is your responsibility to provide complete and current primary *and* secondary insurance information (if applicable). It is your responsibility to advise us of any changes regarding your dental coverage(s) or patient information as soon as they occur (termination of dental benefits, changes regarding dental insurance provider(s), contact information including address and phone numbers, changes to your medical history, etc.)

You will be responsible for all fees incurred and immediate full payment will be expected if:

- Your coverage is not in effect at the time of service.
- You do not reply to requests for additional information from your insurance company or dental benefits provider.
- You do not advise us of changes to your dental coverage prior to treatment.

If insurance payments are sent directly to you, you are responsible to send them to the office with the E.O.B. (Explanation of Benefits).

Pre-Determinations: In order to estimate the patient's responsibility, a pre-determination can be submitted to your insurance company prior to treatment. If you proceed with treatment prior to written approval from your insurance company, full payment will be expected at the time of service.

Claims Submission: We will be happy to assist you with submitting your dental claims.

Broken Appointments: So that we can better satisfy the needs of our patients, please provide 24 hour notice if you are unable to keep an appointment. Messages left to confirm appointments require a call back prior to the appointments.

Biopsies: In addition to fees for treatment rendered at this office, you will be billed separately by LabCorp whenever laboratory fees are incurred.

Responsible Parent: In cases of divorced or separated parents, our policy is that the parent bringing the child into our office must be responsible for the full payment of all fees.

For Patients Without Insurance: Full payment is expected at the time of service.

I have read and completely understand and agree to the above office policies.

| Patient / Guardian (please print) | Patient / Guardian Signature | Date |
|---|---|---|

Little Falls Dental

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Little Falls, NJ 07424
973-256-3912 973-785-2316 f
www.littlefallsdentalnj.com

## Acknowledgement of Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgement)

**Patient Name (please print)** _____

**Parent or Guardian Name (if minor) (please print)** _____

**Signature of Patient or Parent/Guardian (if minor):** ✖ _____

**Date Signed:** _____/_____/_____

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***FOR OFFICE USE ONLY***

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment 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):

_____