515 N. Wood Ave. Suite 102

Linden, NJ 07036

(908) 486-5000

**A black and white logo

Description automatically generated**

[www.lindennjdentist.com](http://www.lindennjdentist.com)

Email: [office@lindennjdentist.com](mailto:office@lindennjdentist.com)

**PATIENT RECORD**

PATIENT NAME: LAST FIRST MIDDLE

CHECK APPROPRIATE BOX: WOMAN MAN TRANSGENDER NON-BINARY/NON-CONFORMNG PREFER NOT TO RESPONSE

MARRIED SINGLE MINOR

ADDRESS: STREET APT/UNIT:

CITY STATE ZIP

DATE OF BIRTH: / / SSN: - -

HOME PHONE: ( ) MOBILE: ( )

EMAIL:

PLACE OF EMPLOYMENT: (IF FULL TIME STUDENT-SCHOOL NAME/GRADE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE: YES NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO

HOW DID YOU HEAR ABOUT US: FAMILY/FRIEND NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

INSIURANCE GOOGLE INTERNET -PLEASE SPECIFY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FACEBOOK INSTAGRAM TIKTOK

BILLBOARD OTHER, PLEASE SPECIFY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION: COMPANY \_\_\_\_\_\_\_\_\_\_ SUBSCRIBER ID # GROUP#

**FAMILY INFORMATION (FOR MINORS ONLY):**

MOTHER/WIFE: (LAST) \_\_\_\_ (FIRST) \_\_\_\_\_\_\_\_\_\_ FATHER/HUSBAND: (LAST) \_\_\_\_ (FIRST) \_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_ \_\_\_ / \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_ / \_\_

HOME PHONE: ( ) HOME PHONE: ( )

MOBILE: ( ) MOBILE: ( )

**EMERGENCY CONTACT INFO:**

CONTACT #1: \_\_\_\_\_\_\_\_\_\_ ­ CONTACT #2: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE: \_\_\_\_\_\_\_\_\_\_ \_\_ RELATIONSHIP: PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL AND DENTAL HEALTH HISTORY**

Are you currently under a physician’s care? \_\_\_\_\_\_

* **Physician** name and Phone #

* **Pharmacy** Name and Phone #

Have you ever been hospitalized or had a major operation? \_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST OF ALL MEDICATIONS (INCLUDING NON-PRESCRIPTION MEDICINE)**

|  |  |  |
| --- | --- | --- |
| NAME OF MEDICATION | DOSAGE | FREQUENCY |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## ALLERGIES (CHECK ALL THAT APPLY)

ASPIRIN ACRYLIC CODEINE METAL RUBBER FOOD

SULFA DRUGS LATEX RUBBER SEASONAL PENICILLIN ANTIBIOTICS \_\_\_\_\_\_

OTHER

NO KNOWN ALLERGIES

## WOMEN (CHECK ALL THAT APPLY)

PREGNANT (\_\_\_\_\_\_ Weeks) RECENTLY HAD A BABY (WHEN )

COULD BE PREGNANT NURSING

TRYING TO GET PREGNANT TAKING ORAL CONTRACEPTIVES

### INDICATE WHICH OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST (CHECK YES OR NO)

AIDS/HIV POSITIVE YES NO

ALZHEIMER’S DISEASE YES NO

ANEMIA YES NO

ANGINA YES NO

ARTHRITIS/GOUT YES NO

ARTIFICIAL HEART VALVE YES NO

ARTIFICIAL JOINT YES NO

ASTHMA YES NO

BLOOD DISEASE YES NO

BLOOD TRANSFUSION YES NO

BRUISE EASILY YES NO

CANCER YES NO

CHEMOTHERAPY YES NO

CHEST PAINS YES NO

COLD SORES/FEVER BLISTERS YES NO

CONGENITAL HEART DISORDER YES NO

CONVULSIONS/TREMORS YES NO

CORTISONE MEDICINE YES NO

DIABETES YES NO

DRUG ADDICTION YES NO

DRY MOUTH YES NO

EMPHYSEMA YES NO

EPILEPSY/SEIZURES YES NO

EXCESSIVE BLEEDING YES NO

EXCESSIVE THIRST YES NO

FAINTING/DIZZINESS YES NO

FREQUENT COUGH YES NO

GLAUCOMA YES NO

HAY FEVER YES NO

HEART ATTACK YES NO

HEART MURMUR YES NO

HEART PACEMAKER YES NO

HEART DISEASE YES NO

HEMOPHILIA YES NO

HEPATITIS A YES NO

HEPATITIS B YES NO

HEPATITIS C YES NO

HERPES YES NO

HIGH BLOOD PRESSURE YES NO

HIGH CHOLESTEROL YES NO

HIVES/RASH YES NO

HYPOGLYCEMIA YES NO

IRREGULAR HEARTBEAT YES NO

KIDNEY PROBLEMS YES NO

LEUKEMIA YES NO

LIVER DISEASE YES NO

LOW BLOOD PRESSURE YES NO

LUNG DISEASE YES NO

MITRAL VALVE PROLAPSE YES NO

PAIN IN JAW JOINTS YES NO

PHYSICAL THERAPY YES NO

PSYCHIATRIC CARE YES NO

RADIATION TREATMENT YES NO

RENAL DIALYSIS YES NO

RHEUMATIC FEVER YES NO

RHEUMATISM YES NO

SHINGLES YES NO

SICKLE CELL DISEASE YES NO

SINUS TROUBLE YES NO

SEXUALLY TRANSMITTED DISEASES YES NO

STOMACH/INTESTINAL PROBLEMS YES NO

STROKE YES NO

SWELLING OF LIMBS YES NO

THYROID DISEASE YES NO

TONSILITIS YES NO

TUBERCULOSIS YES NO

TUMORS/GROWTHS YES NO

ULCERS YES NO

VENEREAL DISEASE YES NO

YELLOW JAUNDICE YES NO

REVIEWED BY DOCTOR \_\_\_\_\_\_\_ DATE BLOOD PRESSURE

**PATIENT (GUARDIAN) SIGNATURE: DATE:**

**NOTICE OF PRIVACY PRACTICES/ HIPPA CONSENT FORM**

**This notice describes how your health information may be used and disclosed by our office and how you can access this information. Please review this document and sign the acknowledgement attached to this form. At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy in addition to providing you with this information and adhering to the new law set in place. This law allows us to:**

* Use or disclose your health information to those involved in your health treatment, i.e. a review of your file by a specialist whom we may involve in your care.
* We may use or disclose your health information for payment services, i.e. we may send a report of progress with your claim to your insurance company.
* We may disclose your health information with our business associates, such as a dental laboratory. Business associates have a written contract with the Doctor, which requires them to protect your privacy.
* We may use your information to contact you, i.e. newsletters, educational materials or other information. We may also contact you to confirm your appointments in lieu of your absence. When the confirmation call is made our office may leave a message on your answering machine or with persons who answer the contact number provided.
* In an emergency, we may also disclose your health information to a family member or another person responsible for your care.
* We may also release your health information if required by law. Exceptions are as follows: we will not disclose your health information without prior written knowledge.
* You may request in writing that we do not disclose your health information as described above, our office will inform you if that request cannot be met. You have the right to know any of the uses or disclosures of your health information beyond the normal uses. As we will need to contact you periodically, we will use whatever address or telephone number you prefer.

**You have the right to:**

Your rights regarding your health information:

* **Right to Access:** You may request copies of your records. A reasonable fee applies for copies and X-rays.
* **Right to Amend:** You may request changes to your records in writing. No original documents will be altered; instead, new information will be added.
* **Right to Restrict Disclosure:** You may request in writing that we not disclose specific information. We will inform you if we cannot accommodate your request.
* **Right to an Accounting of Disclosures:** You may request a list of non-standard disclosures of your health information.
* **Right to File a Complaint:** If you believe your rights have been violated, you may file a complaint with our office or the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

**By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices. I am in full understanding that the notice given to me may be updated in the future, and I will be notified of any amendments to this notice by telephone or mail.**

***If you wish to share your information with family or friends, please put their names in the box below.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | Type of information allowed to disclose | | | Method of disclosure  (Check one or both) | |
| Name/ Date of birth | Relationship | Medical | Billing | Appointments | By phone | In person |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Authorization to Disclose Health Information to Family Members and Friends**

PATIENT (GUARDIAN) SIGNATURE: \_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_

**OFFICE POLICY**

**Insurance Coverage**

We will gladly discuss any insurance questions you may have. **You must understand that your insurance plan is a contract between you and/or your employer and the insurance company.** Magic Smile Dental cannot be held liable for any stipulations or clauses in your plan which alter or adjust the estimated patient’s portion. **In office estimates are done as a courtesy to the patient** and are based on the coverage percentage given to Magic Smile Dental by your insurance company. We are always willing to submit pre-authorization for proposed work at the request of our patients. While the filing of claims is a courtesy that we extend to our patients, all charges are your responsibility on the date the services are rendered regardless of insurance benefits.

**Appointment Confirmations: Appointments must be confirmed at least two days in advance. Unconfirmed appointments may be canceled.**

**FINANCIAL POLICY**

We are committed to providing you with the best possible dental care. If you have dental insurance, we will assist you in maximizing your benefits. However, all charges are your responsibility at the time services are rendered, regardless of insurance coverage.

* **Deposits**: **A 50% deposit** is required for major dental treatments as we do not doublebook our patients appointments. Remaining payment is due at the time services are rendered.
* **Cancellation Policy**: A minimum of **48 hours’ notice is required for cancellations**. A fee of $50 per hour applies for hygiene/general dentist appointments and $300 for specialist visits. Your appointment time is reserved exclusively for you.
* **Balance Due**: Any remaining balance after insurance payment must be paid within 30 days. Unpaid balances after 30 days may be subject to additional collection actions.
* **Collections**: After four months of non-payment, any past-due balance will be sent to a collection agency. A 15% collection agency fee will be added to the outstanding amount.

**I have read the above and fully understand and accept the terms and conditions set forth. I authorize the release of any information relating to my dental claim. I understand I am responsible for all costs of dental treatment regardless of insurance. I understand it is my responsibility to confirm and/or cancel my appointments in a timely manner to avoid any additional fees.**

**TODAYS DATE**: / / \_\_ **SIGNATURE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_