Brook Dental Associates

373 Vosseller Ave Bound Brook ,NJ 08805
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Referrals are our finest complement. To whom may we thank for referring you to our office _____

Patient Information

Date _____ Patient's Name _____ (Last) (First) (Middle)

Address _____ (Street) (City) (State) (Zip)

Home Ph. # (___) _____ Work Ph. # (___) _____ cell Ph. # (___) _____

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

Emergency Contact _____ Ph. # (___) _____

If patient is a full-time student, fill in school name _____

Email Address _____ Soc. Sec. # ___-___-___

Responsible Party Information

Name _____ (Last) (First) (Middle) (Marital Status)

Soc. Sec. #___-___-___ Birthdate ___/___/___ Relationship to Patient _____

Residence _____ (Street) (Apt#) (City) (State) (Zip)

Mailing Address _____ (Street) (City) (State) (Zip)

How long at this address_____ Home Ph.# (___) _____ Work Ph.# (___) _____ Fax# (___) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____

Soc. Sec. #___-___-___ Birthdate ___/___/___ Work Ph.# _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Is policy connected with your union? Yes ___ No ___ Name of Union _____ Local # _____

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

Dental Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit_____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

_____

How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the last two years? ..... YES NO
3. Are you now taking any medication or drugs? ..... YES NO

   If yes, please list: _____
4. A. Have you taken any medication or drugs during the last two years? ..... YES NO

   B. Have you **ever** taken appetite suppressants - fen-phen (fenluramine & Phentermine) or dexfenfluramine or fenflurameine? ..... YES NO
5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? YES NO

   Physician's Name _____ Ph. # (___) _____

   Address _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO

   If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO			

8. Do you ever experience chest pain and/or shortness of breath? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Have you gained more than ten pounds in the last year? ..... YES NO
11. Do you snore? ..... YES NO
12. Has anyone ever told you that you stop breathing while you sleep? ..... YES NO
13. Do you ever wake up from sleep and feel short of breath? ..... YES NO
14. Do you have or have you had any disease, condition or problem not listed ? ..... YES NO

If you, please list: _____

FOR WOMEN ONLY:
Are you pregnant? Yes ___ What month? _____ No ___ Are you nursing? Yes ___ No ___ Are you taking birth control pills? Yes ___ No ___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient Signature _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

NOTICE TO OUR PATIENTS

BROOK DENTAL ASSOCIATES will assist you in filling your insurance claim with Primary insurance company. Should a claim be denied or partial payment made, you the patient and/or insured will be responsible to pay **BROOK DENTAL ASSOCIATES** any remaining balance.

Once we have received payment from your insurance company you will be sent a statement of the remaining balance. This balance is due within 30 days. If you have a Secondary Insurance we will allow 30 days for payment from that insurance company and if no payment is received you will be responsible to pay the balance and seek reimbursement yourself.

I understand that all responsibility for payment for dental services provided for myself or my dependents is mine, due and payable at the time of services are rendered unless arrangements have been made. In the event payments are not received by the agreed due dates, I understand that a 1½% finance charge (18% APR) may be added to my account, in addition to any collection charges. The dishonored check fee is $50.00.

I understand that where appropriate, credit bureau reporting may be obtained.

I understand that it is my responsibility to advise your office of my changes in the information obtained on this form.

I authorize the use of my social security number to file my dental claim.

By signing below I acknowledge that I have read the above statements and understand my responsibility.

Signature of Patient and/or insured_____ Date _____

Witness _____ Date_____

About Insurance

Dental insurance is one of the most beneficial and most misunderstood factors of dental treatment today. This explanation will attempt to clear up many common misconceptions about insurance.

Dental insurance is a contract between the employer and the patient. It has **NO CONNECTION** at all to the provider of dental treatment. The extent of coverage varies greatly from company to company, and sometimes even within the company. It has absolutely nothing to do with level of services provided by the Dentist and the fee charged for these services.

An often misunderstood term by many insurance companies is **"UCR."** This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After the ceiling, coverage for a particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by the employer.

We will make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance claim form at no cost as a courtesy to our patients. We can provide an estimate that will show expected insurance reimbursement and patient share for each procedure. The patient share will be due at the time of treatment unless prior arrangements were made. Should our estimate of patient share be too high, a refund will be made after payment from the insurance company. Likewise, if the estimate is too low, the remainder will be due at that time. Should no insurance payment be made within ninety days of submitted claim, the fee will become the sole responsibility of the patient.

_____
initials

HIPAA OMNIBUS RULE: PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

Date: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ No Preference ☐ First Name Only ☐ Proper Sir Name ☐ Other_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation (_____) _____-_____

☐ Text Message to my Cell Phone (_____) _____-_____

☐ Home Phone Confirmation (_____) _____-_____

☐ Work Phone Confirmation (_____) _____-_____

☐ Email Confirmation _____

☐ **Any of the Above** (if you choose this option please fill in above information)

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ **Any of the Above**

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE. You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

_____ _____

Please *print* name of Patient **Please *sign* for Patient / Guardian of Patient**

_____ _____

Legal Representative / Guardian **Relationship of Legal Representative / Guardian**

office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: ☐ *It was emergency treatment* ☐ *I could not communicate with the patient* ☐ *The patient refused to sign* ☐ *The patient was unable to sign because*_____ ☐ *Other (please describe)*_____

_____

Signature of Privacy Officer