

Pascack Dental Arts

Date _____ / _____ / _____

PATIENT INFORMATION

Patient's Name		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Patient's Date of Birth ____ / ____ / ____	
Street Address			City		State _____ Zip Code _____
Home Phone (____) _____	Work Phone (____) _____	Cell Phone (____) _____	E-mail Address		Social Security No.
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>			Occupation		
Purpose of Visit			How Were you Referred to this Office?		

SPOUSE'S INFORMATION OR GUARDIAN (IF PATIENT IS A MINOR)

Spouse's Name		Home Phone (____) _____	Work Phone (____) _____	Cell Phone (____) _____
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EMPLOYER'S INFORMATION

Employer's Name			
Street Address		City	State _____ Zip Code _____

IN CASE OF EMERGENCY - NEAREST RELATIVE NOT LIVING WITH YOU

Relative's Name		Relationship	Home Phone (____) _____	Work Phone (____) _____	Cell Phone (____) _____
Street Address		City	State _____ Zip Code _____		

PATIENT'S MEDICAL HEALTH INFORMATION

General Health Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>		Physician's Name		Dr's Phone #	
Physician's Street Address			City	State _____ Zip Code _____	
Date of Last Complete Physical ____ / ____ / ____	Results	Are you Taking Medication Now? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Medication _____			
Purpose of Medication					

Are you or have you been treated for:

Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High/Low Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	H.I.V. Positive	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
TB or Lung Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	A.I.D.S.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nervous Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Asthma or Hay Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Have you ever had radiation treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: _____		Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> How Much? _____ How Long? _____	
Are you allergic to: Penicillin: Yes <input type="checkbox"/> No <input type="checkbox"/> Codeine: Yes <input type="checkbox"/> No <input type="checkbox"/> Local Anesthetics: Yes <input type="checkbox"/> No <input type="checkbox"/>		Allergic to Other Medications: _____	
Are you subject to prolong bleeding? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you subject to Fainting Spells? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have excessive urination and/or thirst? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you been hospitalized or had major surgery? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes explain: _____			

WOMEN ►	Are you Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, how long? _____	Any Complications? _____
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Do you have any other Medical Conditions you feel we should know?

DENTAL HISTORY

Do you have previous dental records or x-ray Yes _____ No _____
Date of your last visit to a dentist _____
Last full mouth x-rays were taken when _____
Are you happy with your smile? If not explain _____
Do you wear dentures? Yes _____ No _____
Do your gums bleed on brushing, flossing or eating? Yes _____ No _____
Do you have a bad taste in your mouth Yes _____ No _____
Does food catch between your teeth? Yes _____ No _____
Have your teeth shifted? Yes _____ No _____
Are any of your teeth sensitive to heat, cold or pressure? Yes _____ No _____
Do you grind or clench your teeth? Yes _____ No _____
Do you have pain around your ear? Yes _____ No _____
Does your jaw click? Yes _____ No _____
Are there any sores or growths in your mouth? Yes _____ No _____
Do you use a Water Pik, dental floss or other device? Yes _____ No _____
Do you wish that your teeth were whiter? Yes _____ No _____
Do you wish that your breath was fresher? Yes _____ No _____
Do you smoke/use tobacco products? Yes _____ No _____

I consent to treatment with use of local anesthetic and/or nitrous oxide. To the best of my knowledge, all of the preceeding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform one of the dentists or hygenists at my next appointment, without fail.

Witness Patient, Parent, Guardian Date

PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:

Name _____ Employer Name _____
Address _____ Employer Address _____
Town _____ State _____ Zip _____ Town _____ State _____ Zip _____
Home # _____ SS # _____ Work # _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____
Address _____ Town _____ State _____ Zip _____
Name of Insured _____ DOB of Insured _____ Soc. Sec. # of Insured _____
Insured's Employer _____ Policy or ID # _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance: _____
Address _____ Town _____ State _____ Zip _____
Name of Insured _____ DOB of Insured _____ Soc. Sec. # of Insured _____
Insured's Employer _____ Policy or ID # _____

SIGNATURE ON FILE AUTHORIZATION

- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance carriers
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
- I permit a copy of this authorization to be used in place of the original

Signature of Insured _____ Date _____

Pascack Dental Arts

Robert H. Guller, D.M.D.
Maria E. Grodsinsky, D.D.S.
Dorothy A. Feehan, D.M.D.
Laurie DiMichele, D.M.D.
Cheryl Marcus, D.D.S.

Han Lyu, D.M.D.
Jean Gong, D.M.D.
Tirza, Valenzuela, D.D.S.
Dov Hook, D.M.D.

21 South Kinderkamack Road
Montvale, NJ 07645
Tel: (201) 391-5565
Fax: (201) 391-8747

Pascack Dental Arts

General Informed Consent

I _____ agree to be treated by the doctors of Pascack Dental Arts.

I understand that in most instances there could be more than one treatment choice available to me including no treatment. I further understand that treatment options will be explained to me, but it is my responsibility to ask further questions if I do not fully understand treatment presented to me.

I understand that there are risks involved with having dental treatment performed. These risks include, but are not limited to:

- Swelling, bruising and discomfort
- Infection – which can receive further treatment and /or medication
- Bleeding
- Drug reaction / interaction
- TMJ / MPM dysfunction – Jaw muscle problems
- Allergic reaction – to medication including local anesthetics
- Numbness
- Other/ additional complications

I have read and understand the above information. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. In case of default of payment, I promise to pay any legal interest on the balance due at 1.5 % per month, together with any collection costs of 40% and reasonable attorney fees incurred to effect collection on this account. I believe that I have been given sufficient information and give my consent to be treated by the doctors of Pascack Dental Arts.

Patient or Legally responsible person _____ Date _____
Witness _____ Date _____

**CONSENT FOR USE AND DISCLOSURE OF HEALTH
INFORMATION**

PATIENT GIVING CONSENT:

Name: _____

Address: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment; payment activities, and healthcare options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this Consent form your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient (i.e. parent or guardian), complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Pascack Dental Arts

21 South Kinderkamack Rd., Montvale, NJ 07645
P:201-391-5565; F:201-391-8747

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be stated below.** In addition, the account holder (not necessarily the insurance holder) may receive basic dental treatment information on mailed billing statements.

You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friend (including spouse)

I hereby authorize **Pascack Dental Arts** to release my patient health information regarding my appointments, dental treatment, financial arrangements and insurance to the following named person(s):

Name of authorized person: _____ Relationship _____
Phone number _____

Name of authorized person: _____ Relationship _____
Phone number _____

Name of authorized person: _____ Relationship _____
Phone number _____

Authorization to Leave Health Information by Alternate Means

I authorize Pascack Dental Arts to use telephone numbers and e-mail provided on the Patient Registration Form to leave messages on voice mail, texts and e-mail to remind about appointments and other patient matters.

DO NOT RELEASE INFORMATION TO ANYONE

I understand that my consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and this consent will remain in effect until revoked by me in writing. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: _____ Date of Birth _____
Please Print Name

Signature of patient or patient's authorized representative

Date

Witness name

Signature

Date

