WELCOME TO OUR PRACTICE

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date: _____

E-mail address: _____ *Home phone:* _____

Cell phone: _____*Business phone:*_____

We may contact you at: Home: ☐ *Cell:* ☐ *Work:* ☐

Name: _____ *Soc. Sec.#* _____
Last First Initial

Address: _____

City: _____*State:*_____*Zip:*_____

Sex: __M___F Age:_____ Birth date:_____ Single___Married___Separated___Divorced___

Patient Employed by: _____ *Occupation:* _____

Business Address: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____*Phone* _____

Person responsible for Account _____
Last First Initial

*Relation to Patient:*_____ *Birth date:* _____*Soc. Sec. #*_____

*Home phone:*_____ *Cell Phone:*_____

Address (if different than patient's) _____

City: _____ *State:* _____*Zip* _____

Person Responsible Employed by: _____ *Occupation:* _____

Business Address: _____ *Bus. Phone:* _____

Insurance Co. _____ *Policy #* _____

Is Patient covered by additional insurance? Yes: _____ *No:* _____

Subscriber Name: _____ *Relation to Patient:*_____ *D.O.B* _____

*Address (if different from Patient) :*_____ _____

City: _____*State:* _____*Zip:*_____

Insurance Co. _____*Policy #*_____ *Soc Sec #*_____

DENTAL HISTORY

WELCOME! So that we may provide you with the best possible care please complete this dental history form. ALL INFORMATION IS COMPLETELY CONFIDENTIAL

What is the reason for your visit today? _____

Date of last Dental Visit: _____Last Dental Cleaning: _____Last Full Mouth X-rays:_____

What was done at your last dental visit?_____

Previous Dentist's Name:_____Address:_____

City: _____State: _____Zip: _____Tel. #: _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____

How often do you brush you teeth?_____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

DO YOU HAVE ANY DENTAL PROBLEMS NOW? Yes: _____ No:_____

If yes please describe: _____

ARE ANY OF YOU TEETH SENSITIVE TO:

Hot or Cold? Yes___ No___
Sweets? Yes___ No___
Biting or Chewing? Yes___ No___
Have you noticed any mouth odors or bad tastes? Yes___ No___

Any other oral lesions? Yes___ No___

HAVE YOU EVER HAD:

Orthodontic treatment? Yes___ No___
Oral Surgery? Yes___ No___
Periodontal Treatment? Yes___ No___
Your teeth ground or your bite adjusted? Yes___ No___
A serious injury to the mouth or head? Yes___ No___
If so, please describe, including cause:
_____

DO YOUR GUMS BLEED OR HURT? Yes___ No___

Have your parents experienced gum disease or tooth loss? Yes___ No___
Have you noticed any loose teeth or change in you bite? Yes___ No___

DO YOU:

Clench or grind your teeth while awake or asleep? Yes___ No___
Bite your lips or cheeks regularly ? Yes___ No___
Hold foreign objects with your teeth? (Pencils, pipe, pins, nails, fingernails) Yes___ No___
Have tired jaws especially in the morning? Yes___ No___
Smoke or chew tobacco? Yes___ No___

HAVE YOU EXPERIENCED:

Clicking or popping of the jaw? Yes___ No___
Pain in Joint, Ear, Side of Face? Yes___ No___
Difficulty in opening or closing the mouth? Yes___ No___
Headaches, neck aches, or shoulder aches? Yes___ No___
Sore Muscles (neck, shoulders) Yes___ No___

ARE YOU SATISFIED WITH YOUR TEETH'S APPERANCE? Yes No

Would you like to keep all of your teeth all of your life? Yes___ No___
Do you feel nervous about having dental treatment? Yes___ No___
If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe_____

VILLAGE DENTAL, PA

MEDICAL HISTORY

Patient Name _____ **Birth Date**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes	O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	O Yes	O No	If yes, please explain: _____
Do you take, or have taken, Phen-Fen or Redux?	O Yes	O No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	_____
Are you on a special diet?	O Yes	O No	
Do you use tobacco?	O Yes	O No	
Do you use controlled substances?	O Yes	O No	

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex

☐Sulfa drugs ☐Other If yes, please explain: _____

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

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growth	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
						Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No _____

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____DATE:_____

Village Dental
255 Main Street
Ridgefield Park, NJ 07660

Financial Policies and Procedures

Office Policy Regarding Dental Insurance
We will submit insurance claims as a courtesy on your behalf and utilize your benefits within your policy guidelines. Completion of recommended treatment will be needed in order to maximize your dental insurance benefits. We make every attempt to determine your insurance plan benefits. However, any treatments rendered that is not covered by your insurance plan due to limitations of coverage will be your financial responsibility.

Dental Insurance Co-payments and Deductible
Although we submit insurance claims on your behalf, Village Dental, P.A. expects payment of all co-pays and deductibles at the time of service. Under no circumstances will Village Dental, P.A. waive co-pays or deductibles, as it is legally impermissible.

Financial Arrangements
We are pleased to offer a number of financial arrangements to make your treatment affordable. The financial coordinator will discuss these options once you and the doctor have agreed upon a treatment plan.

Cancellation Policy
We at Village Dental, P.A. respect your time and reserve appointments specifically for you. We understand that emergencies arise. However, we expect 48-hour notification for cancelled appointments. Any non-emergency cancellation less than 48 hours in advance will be subject to a $50.00 cancellation fee billed directly to the patient or guardian.

Patient Signature Date

VILLAGE DENTAL
255 Main Street
Ridgefield Park, New Jersey 07660
201-440-9190

FINANCIAL AGREEMENT

FINANCIAL ARRANGEMENTS: For you convenience, we offer the following methods of payment.

CASH___CHECK___CREDIT CARD___I wish to make financial arrangements___
Please check your preference

CO-PAYS ARE DUE AT TIME OF SERVICE

LATE CHARGES: If the entire balance is not paid within 25 days of date of service, a late charge of 1.5% on the unpaid balance will be assessed. There will be a $1.00 billing charge for all non-insurance billing. I realize that failure to keep this account current may result in the office being unable to provide additional services except for emergencies or where prepayment is made for services.

Accounts 30 days past due will be considered in default and I understand that it may become necessary to refer my account to a collection agency. I also understand that if my account is referred, I am responsible to pay amounts, including collections agency fees in the amount of 30% of the default placed for collections. The collection agency fees in the above amount shall be come due and owing at the time the account is placed for collections and may be assessed and added to the balance at that time.

SIGNATURE OF PATIENT (parent if minor)_____DATE_____

PATIENT CONSENT FORM

I understand that, under the **Health Insurance Portability & Accountability Act of 2010 (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have take action relying on this consent.

I give permission for my account and or treatment to be discussed with the following people:

_____ _____
(Person's Name) **(Relationship)**

_____ _____
(Person's Name) **(Relationship)**

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Village Dental
255 Main Street
Ridgefield Park, NJ 07660

VILLAGE DENTAL

Take our...

SMILE ASSESSMENT

Yes	No	
❑	❑	Are you happy with the appearance of your teeth?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Do you feel your teeth are too long or too short?
❑	❑	Do you like the color of your teeth?
❑	❑	Are you interested in improving the appearance of your teeth?
❑	❑	Are you familiar with the benefits of dental implants?
❑	❑	Are you anxious or fearful of treatment?
❑	❑	Are you happy with the alignment of your teeth?
❑	❑	Have you ever been told that you snore in your sleep?

Is there anything holding you back from achieving your perfect smile?

❑ Fear ❑ Time ❑ Cost ❑ Other _____

Please feel free to explain any answers. _____

_____

_____

255 Main Street • Ridgefield Park, NJ 07660 • (201) 440-9190 • www.VillageDentalNJ.com