CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Name (Last, First, Middle): _____

Date of Last Physical Exam: / /

Are you now or have you recently been under a physician's care? ____ YES ____ NO

Reason: _____

Have you ever been a patient in a hospital or had any serious illness?

Explain: _____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
___	___	Arthritis	___	___	Hepatitis or Jaundice	___	___	Prolonged Bleeding
___	___	Rheumatic Fever	___	___	Liver Disease	___	___	Fainting Tendency
___	___	Heart Trouble	___	___	Cancer or Tumor	___	___	Epilepsy
___	___	Heart Murmur	___	___	Tuberculosis	___	___	Thyroid Disease
___	___	High/Low Blood Pressure	___	___	Diabetes	___	___	Glaucoma
___	___	Chest Pain	___	___	Kidney/Bladder Trouble	___	___	Radiation Treatment
___	___	Stroke	___	___	Anemia	___	___	Mental Disorders
___	___	Shortness of Breath	___	___	Lung Disease	___	___	HIV or AIDS
___	___	Asthma or Hay Fever	___	___	Venereal Disease	___	___	Prosthetic Joint Replacement
___	___	Sinus Trouble	___	___	Blood Disease	___	___	Blood Transfusion

Check any of the following that you are taking or have taken:

YES	NO		YES	NO		YES	NO	
___	___	Cortisone Drugs	___	___	Anticoagulants	___	___	Tranquilizers
___	___	Steroids	___	___	Blood Thinners	___	___	Sedatives

Are you taking any other medication? _____

Are you allergic to or do you suffer ill effects from any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Penicillin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Aspirin	___	___	Household Bleach	___	___	Other: _____

Women Only:

Are you pregnant? ____ Yes ____ No If yes: How many months? _____ Are you breast feeding? _____

Are you presently taking medicine of any kind routinely? (Birth control pills, shots or implant, hormone therapy. Etc.)

Explain: _____

The above information is true to the best of my knowledge.

RESPONSIBLE PARTY OR PATIENT:

Name: _____

Signature: _____

NEW PATIENT INFORMATION FORM

Name (Last, First, Middle): _____

Address: _____

Preferred Name: _____ S.S.N. ____-____-____ Sex: M / F DOB: / /

Phone: (____)_____ Marital Status: _____ Referral Source? _____

Email: _____

Preferred Method of Contact: (circle one) Call Text Email

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: (____)_____ Email: _____

Address: _____

PRIMARY DENTAL INSURANCE COVERAGE

Name: _____ Relationship to Patient: _____

Address: _____

S.S.N. ____-____-____ Employer: _____

DOB: / / Address: _____

Plan Name: _____ Group No. _____ Individual Yearly Deductible: _____

Insurance Co.: _____ Family Yearly Deductible: _____

Insurance Address: _____

SECONDARY DENTAL INSURANCE COVERAGE

Name: _____ Relationship to Patient: _____

Address: _____

S.S.N. ____-____-____ Employer: _____

DOB: / / Address: _____

Plan Name: _____ Group No. _____ Individual Yearly Deductible: _____

Insurance Co.: _____ Family Yearly Deductible: _____

Insurance Address: _____

PHARMACY INFORMATION

Name: _____ Phone: _____

Address: _____

CANCELLATION / NO-SHOW POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you; and when it is missed, that time cannot be used to treat another patient who needs dental care as well.

We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances, and our staff does their best to come to a solution as effectively as possible.

Our policy is as follows:

We require that all patients give our office *at least* 24 hours notice in the event that their appointment needs to be rescheduled or canceled. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$50.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage and look forward to fulfilling all of your dental needs.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ have read and understood the Appointment
(Patient's Name) Cancellation Policy

_____

(Signature of Patient) (Date)

Shore Dental
20 N Main St.,
Manahawkin, NJ 08050
Phone: (609) 978-1212
Fax: (609) 978-1714

CONSENT FOR DENTAL TREATMENT

_____ _____

PATIENT'S NAME ***DATE***

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITALING.

_____ **1.TREATMENT**
I understand that I may have the following treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, impacted tooth removal, Root Canals, Implants, treatment of periodontal disease or other work deemed necessary.

_____ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ **3. RISKS OF DENTAL ANESTHESIA**
I understand that pain, bruising and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue or associated facial structure can occur with "shots". About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

_____ **4. FILLINGS**
I understand that a more extensive restoration than originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

_____ **5. CROWNS, BRIDGES, INLAYS, AND ONLAYS**
I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication. It is my responsibility to return within 1 month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

_____ **6. DENTURES**
I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent". I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related problems such as: shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time, and there is a small number of patients who never do. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is required due to my delay, additional fees may be incurred.

_____ **7. EXTRACTIONS**

Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to: pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw and loss of feeling in my lip or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____ **8.PERIODONTAL DISEASE**

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____ **9. ROOT CANAL THERAPY**

I realize root canal therapy has a very high success rate, however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth not restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. [understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough might need further surgery or treatment by a specialist at additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed which, if not placed right away, might lead to fracture of the tooth and possible extraction.

_____ **10. MINI DENTAL IMPLANTS**

I understand the purpose of this dental implant procedure IS to provide support to an existing denture or partial denture. In the event that the implant fails, they will be removed through a subsequent surgical procedure. I understand that one or more of the implants may fracture during insertion or during the implant's life cycle. If a fracture occurs, I give consent to leave the implant in my jaw or remove it, under professional conditions and using professional judgment. I further understand that swelling, infection, bleeding and/or pain may be associated with this or any surgical procedure, and that said conditions may occur during the life of the implants. I also understand that temporary or permanent numbness may occur in my tongue, lip(s) , chin, gum, or jaw as a result of this procedure.

_____ **11.CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care. I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English or this has been translated to me in my own language. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with the treatment. I hereby give my consent for the treatment I have chosen.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT:

I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English or this has been translated to me in my own language. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with the treatment. I hereby give my consent for the treatment I have chosen.

_____ _____

Patient or Guardian's Signature **Date**

_____ _____

Doctor's Signature **Date**

_____ _____

Witness' Signature **Date**

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare 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 prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private 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 any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

HIPAA Compliance Patient Consent Form

Patient Name:

Responsible Party Name:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Patient Signature:

_____