

PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Birthdate: _____ Soc. Sec.: _____ Gender: Male Female
Address: _____ Apt./Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext: _____
Mobile: () - _____ Fax: _____ Email: _____
Employer: _____ Phone: () - _____ Occupation: _____
Referred By: _____ General Dentist: _____
Have you been seen in this practice before today? Yes No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Relationship to Patient: patient spouse child other - please specify _____ Soc. Sec.: _____
Address: _____ Apt./Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext: _____
Mobile: () - _____ Fax: _____ Email: _____
Employer: _____ Phone: () - _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Ins. Co. _____	Ins. Co. _____
Group #: _____ Phone: _____	Group #: _____ Phone: _____
Employer: _____	Employer: _____
Employee (if other than patient)	Employee (if other than patient)
Name: _____	Name: _____
Birthdate: _____ Soc. Sec.: _____	Birthdate: _____ Soc. Sec.: _____
Subscriber #: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female	Subscriber #: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female

Signature (parent or guardian if patient is a minor) _____ Date _____

Signature of authorized representative of _____ Date _____
David M Book DMD Practice Limited to Endodontics

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Today's date: _____ Date of Birth: _____

MEDICAL HISTORY

Name of Physician: _____ Phone#: _____ Date of last visit: _____

Emergency contact - Name: _____ Phone #: _____

Your current physical health is: Good Fair Poor

Have you ever had any serious operations? Yes No If yes, please explain _____

Are you currently under the care of a physician? Yes No Please explain: _____

Please CIRCLE if you have been treated for or told that you have:

Abnormal bleeding.....Anemia.....Blood Disorders.....Blood Transfusion.....Hemophilia..... ARC, AIDS or HIV+
Arthritis.....Asthma or Hay FeverCancer/Tumor.....Chemo/Radiation therapy.....Kidney/Liver Disease.....Ulcers/Colitis
Diabetes.....Glaucoma.....Hepatitis /Jaundice.....Emphysema.....Tuberculosis.....Difficulty Breathing/Lung Problems
Congenital Heart Defect.....High/Low Blood Pressure.....Heart AttackHeart Murmur.....Heart Surgery
Mitral Valve Prolapse.....Pacemaker..... Prosthetic Heart Valve.....Rheumatic Fever.....Prosthetic (artificial) Joints
Drug Addiction.....Epilepsy/Seizures.....Fainting spells.....Severe/Frequent Headaches.....Stroke/CVA.....Venereal Disease
Osteoporosis

For the following questions, CIRCLE Y or N, whichever applies:

- | | | | |
|-----|--|-----|---|
| Y N | Have you experienced unexplained weight loss? | Y N | Do you experience shortness of breath? |
| Y N | Have you ever had a reaction from anesthetic? | Y N | Do you smoke or use smokeless tobacco? |
| Y N | Do you drink alcoholic beverages? | Y N | Have you had a prolonged cough? |
| Y N | Do you take a daily dose of Aspirin? | Y N | Do you bruise easily? |
| Y N | Is extreme thirst a problem? | Y N | Do your ankles swell? |
| Y N | Do you sweat at night or get cold sweats? | Y N | Do you get persistent swollen neck glands? |
| Y N | Have you ever had a major operation? | Y N | Have you ever had pain in your heart/chest? |
| Y N | Have you ever taken any diet control medications such as Fen Phen? | | |

Do you have allergies? If yes, please fill out following:

Check if you are allergic to or have had problems with the following:

- Penicillin ; Codeine ; Erythromycin; Tetracycline; Local injected anesthetics; Non gold jewelry; Latex
- Other _____

Do you take any medications? If yes, please fill out following:

List any prescription or over the counter medications which you are taking:

Name of Medication:	Amount taken:	How often:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WOMEN ONLY

Please answer the following:

Are you pregnant? **Y N** If yes, list due date _____ ; Are you presently nursing? **Y N**

Do you take oral contraceptives? **Y N** If yes, please list name and dosage _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize my insurance company to pay to Dr. David M. Book all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. David M. Book to release all information necessary to secure the payment of benefits.

I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.

I understand that a 1.5% interest fee will be added per month for outstanding balances if there is no payment received within 30 days.

I understand that a \$20 fee will be added for accounts that go to collections.

Since at each visit treatment plans are presented and the work to be done is explained to me before treatment is begun I give Dr. David M. Book my consent to perform any needed dental treatment, including the use of local anesthetic as needed.

Signature

Date

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice (e.g. appointments)

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Date: _____ Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

David M. Book, D.M.D.

277 U.S. Highway 206, Suite 206
Flanders, NJ 07836

Phone: (973) 598-1161

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

- Payment by cash
- Payment by check
- Payment by credit card
- Automatic monthly billing to your Visa or MasterCard
- Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Print your name here and sign below

x _____
Date: _____

COPYRIGHT, 1995,R.M.D.P.