Welcome!

THE smile CENTER OF NEW JERSEY

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

Patient Information

Name____ Soc. Sec. #____________________
Last Name *First Name* *Initial*

Address____

City___________________________ State _______ Zip_________ Home Phone______________________

Cell Phone____________________ Email____

Sex F M Age__________ Birthdate_________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by__________________________________ Occupation _______________________

Business Address____________________________________ Business Phone_____________________

Notify in case of emergency______________________________ Home Phone______________________

Cell Phone____ Business Phone____________________

Email____

Referred by Google Facebook Insurance Website Other ____

Primary Insurance

Person Responsible for Account____
Last Name *First Name* *Initial*

Relation to Patient_____________________ Birthdate______________ Soc. Sec. #__________________

Address (if different from patient)__________________________________ Home Phone_________________

City____________________________________ State__________ Zip______________________

Cell Phone_______________________ Email____

Person Responsible Employed by________________________________ Occupation_________________

Business Address____ Business Phone________________

Insurance Company____ Phone______________________

Contract #____________________ Group #_____________________ Subscriber #__________________

Name of other dependents under this plan____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_______________________ Relationship to Patient_______________ Birthdate_____________

Address (if different from patient)__________________________________ Soc. Sec. #____________________

City__________________________ State________ Zip__________ Home Phone__________________ Cell

Phone____________________________________ Email______________________________

Subscriber Employed by____________________________________ Business Phone__________________

Insurance Company______________________________________ Phone__________________________

Contract #___________________ Group #_____________________ Subscriber #_____________________

Name of other dependents under this plan____

Dental History

What would you like us to do today?______________________ Are you in dental discomfort today?__________

Former Dentist________________ Address______________________________

Dentist's Email__________________________ Phone______________________

Date of last dental care____________________ Date of last x-rays____________________

Check (X) yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath
☐ Y ☐ N Bleeding gums
☐ Y ☐ N Clicking or popping jaw
☐ Y ☐ N Food collection between teeth
☐ Y ☐ N Grinding or clenching teeth
☐ Y ☐ N Loose teeth or broken fillings
☐ Y ☐ N Periodontal treatment
☐ Y ☐ N Sensitivity to cold
☐ Y ☐ N Sensitivity to hot
☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Sores or growths in mouth

How often do you brush?____________________ Floss?____________________

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

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about our dental health or previous treatment______________________________

Medical History

Physician's name__________________________ Phone____________________

Date of last visit________________ Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe______________________________

Are you currently under physician care? ☐ Y ☐ N If yes, describe______________________________

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approx. dates______________________________

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Have you ever used a bisphosphonate medication? Brand names include Fosamaz, Actonel, Atelvia, Didronel and Boniva ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (X) the box if you have/had any of the following:

☐ AIDS/HIV Positive
☐ Anaphylaxis
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Atopic (allergy prone)
☐ Back problems
☐ Blood disease
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatments
☐ Cough, persistent
☐ Cough up blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Food Allergies
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
Describe: ____________
☐ Hemophilia/Abnormal Bleeding
☐ Herpes
☐ Hepatitis
☐ High blood pressure
☐ Jaw pain
☐ Kidney disease or malfunction
☐ Liver Disease
☐ Material Allergies
(**latex**, wool, metal, chemicals)
☐ Mitral valve prolapse
☐ Nervous problems
☐ Pacemaker/Heart surgery
☐ Psychiatric care
☐ Rapid weight gain or loss
☐ Radiation treatment
☐ Respiratory treatment
☐ Respiratory disease
☐ Rheumatic/Scarlet fever
☐ Shingles
☐ Shortness of breath
☐ Skin rash
☐ Spina Bifida
☐ Stroke
☐ Surgical implant
☐ Swelling of feet or ankles
☐ Thyroid disease or malfunction
☐ Tobacco Habit
☐ Tuberculosis
☐ Ulcer/Colitis
☐ Venereal Disease

Is patient currently taking any medications? If yes, list all:

____
____

Does patient have drug allergies? If yes, list all:

____
____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by The Smile Center to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform The Smile Center.

I authorize the insurance company indicated on this form to pay to The Smile Center all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.

I authorize The Smile Center to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or discloseyour health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

____

____

Please print your name here

____

Signature *Date*

FINANCIAL AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family without any misunderstandings regarding your account.

Our professional services are rendered to patients, thus patients are responsible for charges for treatments rendered. We are unable to provide services on the assumption that the charges will be paid by the insurance company (**AS WE CAN ONLY GIVE ESTIMATES**). The insurance company is responsible to the insured patient. With or without insurance coverage, patients are responsible for full payment of the total bill, unless prior arrangements have been made.

- Payments are due and payable as services are rendered.
- The following methods of payment are accepted: Cash, Checks, Visa, MasterCard, Discover, and Care Credit.
- **Insurance assignment and management:**
    - Patients must provide our office with accurate/current insurance billing information at the time of their appointment, or they are responsible for payment in full.
    - Insurance benefits are a contract between the patient and his/her employer.
    - The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor.
    - Patients are responsible for paying their deductible and their portion at the time of service. Patients are also responsible for paying all charges not covered by their insurance plans including all fees considered above their insurance policy's usual and customary fee schedule.
    - The office will submit a claim up to two times per appointment. Further insurance appeal becomes to patient's responsibility.
    - As an office courtesy, we will accept assignment for the primary insurance coverage. We will also submit to secondary insurance as a courtesy once per date of service. It is the patient's responsibility if a balance remains after 30 days from original submit date to secondary insurance.
- Patients are responsible for balance in full after 60 days even if their insurance company has not paid. Further insurance appeal becomes the patient's responsibility.
- The practice cannot carry balances longer than 90 days. Patients will be informed that their accounts are delinquent before any collection efforts are made. After 3 attempts to contact patient about the balance, then the account be turned over to collection agency or Small Claims and the patient will responsible for additional fees. ***You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 20% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.***

  Patient's Initials:___________

- Treatments such as Root Canal Therapy, Crown(s), Denture(s) and other cosmetic procedures such as Whitening require a deposit before treatment is started. The deposit amount must be no less than 1/2 of the total cost. The remaining balance must be paid in full before the final insert and completion of treatment.

- A service charge of $50.00 will be assessed to your account for any checks returned by your financial institution.

- **Broken and Missed Appointments:** We reserve time specifically for you in order to meet all of your dental concerns and needs, so we ask for at least 48 hours' notice for any cancellation and/or rescheduling of an appointment to avoid a $50 charge for our lost time. Exceptions to this rule can be determined only on an individual basis according to circumstances. Work is not an extenuating circumstances you should let you employer know ahead of time that you are unavailable for work at your appointment time.

I have read and accepted the above Financial Agreement. I understand it, and agree to all payment terms regarding my account.

____ ______________________

Patient/Parent/Guardian Signature **Date**

____ ______________________

Office Staff Signature Date