Patient Name: _____
(Last) (M.I.) (First)
Preferred Name:_____
Marital Status:_____
Date of Birth:_____
Mailing address:_____
City_____ State _____Zip_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
Email Address:_____
How did you hear about us?_____

Primary Dental Insurance: ID #_____
Insurance Name:_____
Phone #:_____
Group #:_____
Employer:_____
Subscriber's Name:_____
Subscriber's DOB:_____ SS:_____

Secondary Dental Insurance: ID#_____
Insurance Name:_____
Phone #:_____
Group #:_____
Employer:_____
Subscriber's Name:_____
Subscriber's DOB:_____ SS:_____

Communication Preferences:

I DO/DO NOT want to be receive reminders via text

I DO/DO NOT want to receive reminders via email

I DO/DO NOT want to receive hygiene reminders via postcards

Dental History:
Are you currently having a dental problem?_____
_____
Date of last x-rays? _____Date of last cleaning?_____
Y/N Have you ever had gum treatment
Y/N Do your gums bleed or hurt when you brush?
Y/N Are you teeth sensitive to hot or cold or sweets?
Y/N Do you clench or grind your teeth?
Y/N Are you happy with the appearance of your teeth?
Y/N Have you noticed your teeth shifting?
Y/N Do you snore? Or your significant other?

Have you ever had any of the following diseases or conditions? (Circle Y to those that apply)

Y/N Arthritis	Y/N Acid Reflux
Y/N Artificial Valve	Y/N Artificial Joints
Y/N Asthma	Y/N Blood Disease
Y/N Cancer	Y/N Cholesterol
Y/N Depression	Y/N Diabetes
Y/N Dizziness/Vertigo	Y/N Dry Mouth
Y/N Epilepsy	Y/N Excessive Bleeding
Y/N Fainting	Y/N Glaucoma
Y/N Head Injuries	Y/N Heart Disease
Y/N Heart Murmur	Y/N Hemoglobin
Y/N Hepatitis	Y/N High Blood Pressure
Y/N HIV	Y/N Kidney Disease
Y/N Liver Disease	Y/N Low Blood Pressure
Y/N Mental Disorder	Y/N Nervous Disorder
Y/N Osteoporosis	Y/N Pacemaker
Y/N Radiation Treatment	Y/N Respiratory Problem
Y/N Rheumatism	Y/N Sinus Problem
Y/N Stomach Problems	Y/N Stroke
Y/N Thyroid Condition	Y/N Tobacco
Y/N Tuberculosis	Y/N Tumor
Y/N Ulcers	Y/N Venereal Disease

Please list any serious medical conditions not listed above:

_____

_____

Are you ALLERGIC to any of the following?

Y/N Amoxicillin/Penicillin	Y/N Codeine
Y/N Erythromycin	Y/N Latex
Y/N Dental Anesthetic/Epinephrine	

Are you ALLERGIC to any other drugs?

_____

Please list current medications:

_____

_____

_____

For Women:
Are you pregnant? ____Yes____Wks____No
Do you take birth control pills?___Yes___No

Do you need to be pre-medicated before dental treatment? If so, please list reason

_____

DENTAL OFFICE INFORMED CONSENT

It is very important to us that you, our patient, understand that the dental treatments and procedures are not to be taken as being routine or without risk or complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individuals satisfaction. When dealing with the human body, there are potentially many variables, some predictable and others not. Complication rates in dentistry are low but they do exist. Even minor procedures such as "fillings" can lead to other complications that can't be foreseen, such as sensitivity, root canal, crowns, or extraction. For example, a "Novocaine" injection could lead to an allergic reaction, anaphylaxis, trismus, facial hemorrhage, swelling, and bruising. Granted, these are fairly uncommon occurrences, but individuals undergoing treatment should be aware of this before consenting. These complications can be transient or may persist requiring further treatments. In general, complications to treatment include, but are not limited to pain, swelling, bleeding, infection, fractures, and other nerve problems.

PHOTO RELEASE –for patients 18 and over

I agree/do not agree (please circle) to allow Nathan C Steele DMD PA to use photos of my teeth for educational, marketing, or promotional usage. Only pictures of my teeth or smile will be used, no full facial photos will be used.

FINANCIAL POLICY

1. PATIENTS WITH INSURANCE COVERAGE:

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help obtain the appropriate benefits from your insurance carrier as a courtesy, but it is the patient's responsibility to understand their benefits. If your coverage changes, it is your obligation to inform our office before treatment is started. If we are not in-network with your new coverage, you may be responsible for the full fee. Routine treatments are generally performed without submitting a request of pre-estimate benefits. Upon request, we will gladly get a pre-estimate for any treatment recommended. Sometimes, the insurance carrier may pay alterative benefits for treatment provided (for example, silver fillings vs. white fillings). In these cases, you are responsible to pay for the difference.

2. PATIENTS WITHOUT DENTAL INSURANCE:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, Check, Mastercard, Visa, Discover, American Express, and Debit cards. We offer patient financing plans, such as Care Credit.

3. All Patients

a. All procedures involving lab work will require a 50% down payment, and the remaining balance due at the time of insert, unless other financial arrangements have been made prior to treatment.

b. Checks returned from the bank are subject to a $30.00 service fee

c. Accounts delinquent more than 60 days are subject to a 1.5% per month finance charge. If your account is sent to collections, you will be responsible for additional fees up-to 50% of your unpaid balance.

BROKEN APPOINTMENT POLICY

Your scheduled appointment is a commitment between you and our office. We do our best to contact you with courtesy reminders prior to your visit via personal phone calls, emails and text messages.

If you are unable to keep your appointment, we ask you to let us know at least 48 hours prior to your visit. If we are not notified via phone call, you may be subject to a cancellation charge of $50 for every hour of reserved appointment time and $75 for every hour for high demand appointment times (after 4 pm and Saturday appointments).

I have read and agree to the above dental office informed consent, financial policies and broken appointment policy.

X_____ _____

Signature of Patient/Parent/Guardian Date

Acknowledgment of receipt of notice of privacy practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____

PATIENT'S COPY

NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
• The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201 202-619-0257 or Toll Free: 1-877-696-6775

Nathan C Steele DMD
17 Monroe Street
Bridgewater NJ 08807
(908) 526-2113