PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Alt. Phone (____)_____ Email address:_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security # _____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (____)_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ HIV / AIDS or Other Immunosuppressive Disorders
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, please describe _____

_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

Joanna Kurman, DDS
112 Main Road • Montville. NJ 07045 • (973) 335-9432 • Fax: (973) 335-3504

FINANCIAL POLICY

Welcome to our practice and thank you for choosing our office for your dental health care we are committed to providing the highest quality of dental care possible and your satisfaction and comfort are our utmost priority this power this policy as well as other health insurance forms that we have provided must be read agreed to and signed prior to rendering of dental treatment.

For your convenience we accept cash, personal checks, and major credit cards. We also offer interest rate financing through CareCredit. For those without dental insurance, payment is expected in full on day of services that are completed. If your treatment is not completed on the day of your appointment then we will ask for a 50% deposit on the day treatment is started and the remaining balance when treatment is completed. If you have dental insurance we will as a courtesy complete the insurance forms and submit claims for payment. However, if you have a copayment for services rendered, your portion is expected at the time of treatment.

We will be more than glad to work with your insurance company and handle all the processing of claims. Please be aware that ultimately you are responsible in full for all treatment rendered.

Thank you for reading and understanding our office financial policy. Should you have any questions or concerns, please feel free to ask them at any time. We wish to be of assistance in any way we can.

Sincerely,
Joanna Kurman, DDS

_____ _____

Signature of Patient/Guardian Date

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ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

(HIPPA)

I,_____

have received a copy of this office's Notices of Private Practices. A copy of this signed and dated acknowledgement shall be as effective as the original. My signature will also serve as a Protected Health Information (PHI) document release should I request documents be sent to other attending doctor/treatment facilities in the future.

_____ _____

Signature of Patient/Guardian Date