HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: ☐ M ☐ F

BIRTHDATE _____ How did you hear about our office? _____

Reason for this Visit _____ TODAY'S DATE _____

RESPONSIBLE PARTY/BILLING INFORMATION

NAME Last _____ First _____ Middle Initial _____ Marital Status _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

PREVIOUS ADDRESS (if less than 3 yrs) Street _____ City _____ State _____ Zip _____ How long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. OF YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____

EMPLOYER _____ OCCUPATION _____

SOC. SECURITY # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ EMAIL _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____

CELL PH. _____ WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

POLICY HOLDER'S NAME _____

POLICY HOLDER'S EMPLOYER _____

INSURANCE CO. _____

MEMBER ID or SOCIAL SECURITY # _____

GROUP # _____ PHONE NO. _____

SECONDARY INSURANCE (If applicable)

POLICY HOLDER'S NAME _____

POLICY HOLDER'S EMPLOYER _____

INSURANCE CO. _____

MEMBER ID or SOCIAL SECURITY # _____

GROUP # _____ PHONE NO. _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Date of last COMPLETE Dental Exam		
Date of Last FULL MOUTH X-RAYS (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?	☐	☐
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (Circle)	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Name of Previous Dentist:		
City: State:		
How do you feel about your teeth?		
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment (scale of 1 to 4)		
Fear: Trust:		
Cost: Time:		

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE NOW?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever used a BISPHOSPHONATE MEDICATION? (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)	☐	☐
Are you PREGNANT?	☐	☐
Do you use CIGARS, CIGARETTES, CHEWING TOBACCO, or a VAPE? (Circle)	☐	☐

PLEASE ✓ YES OR NO TO THE FOLLOWNG (YES IF YOU HAVE HAD OR PRESENTLY HAVE):

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Epilepsy	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Fainting	☐	☐	Rapid weight loss/gain	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart Murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems	☐	☐	Shingles	☐	☐
Asthma	☐	☐	(Describe) _____			Shortness of breath	☐	☐
Back problems	☐	☐	Hemophilia	☐	☐	Skin rash	☐	☐
Blood disease	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease	☐	☐	Thyroid disease	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tonsillitis	☐	☐
Cortisone treaments	☐	☐	Mitral valve prolapse	☐	☐	Tuberculosis	☐	☐
Cough	☐	☐	Nervous problems	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? (Circle)

Aspirin Local Anesthetic Erythromycin Latex (Ballons, gloves) Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications, substances, materials or foods?

If so, please list or write NONE:

FAMILY PHYSICIAN _____ PHONE NO. _____

PATIENT (or Guardian) Signature _____ Date: _____ DENTIST Signature _____

PRIVACY NOTICE

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully.

Introduction

At Towne Centre Family Dental and the Implant and SmileMakeover Studio, we are committed to treating information about you and your health responsibly. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective September 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record and Information

Each time you visit Towne Centre Family Dental and the Implant and SmileMakeover Studio, a record of your visit is made. Typically, this record contains your symptoms, examination, diagnoses, treatment, lab results, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A basis for planning your care and treatment
- A means of communication among many health professionals who contribute to your care
- A legal document describing the care you received
- A means by which a third-party payer can verify that services were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials
- A source of data for our planning and marketing
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Towne Centre Family Dental and the Implant & SmileMakeover Studio, the information belongs to you. You have the right to:

- Inspect and copy your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Towne Centre Family Dental and the Implant & SmileMakeover Studio are required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternate locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will e-mail the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization. For more information, please contact our privacy officer, Nancy, at 908-874-4555.

Patient Name: _____

Date: _____

By signing this form, you acknowledge that Towne Centre Family Dental and the Implant & SmileMakeover Studio has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

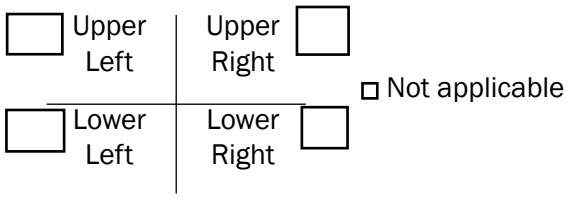
By signing, I assert that the following are true:

- ☑ I have received Towne Centre Family Dental's Privacy Notice.
- ☑ Towne Centre Family Dental has given me the chance to discuss my concerns and questions about the privacy of my health information.
- ☑ I wish to place the following restrictions on the use and/or disclosure of my personal health information: _____

Signature _____ **Date** _____

NEW PATIENT QUESTIONNAIRE

If you are having a dental problem, please circle your area of concern



1. What is your pain level on a scale from 0 (none) to 10 (most) 0---1---2---3---4---5---6---7---8---9---10

If in pain, how frequent? (circle) Occasionally ☐ Daily ☐ Constant ☐

2. Your perception of your dental health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

3. How is your chewing ability?

☐ Eating is very difficult because of the condition of my teeth
☐ There are certain foods that I can't eat normally
Examples: _____
☐ There are no limitations on my ability to eat or chew

4. How do you feel about the appearance of your front teeth?

☐ I've always hoped that something could be done to improve my smile
☐ My smile is not ideal, but it is not a priority at this time
☐ I like my smile and have no concerns about the appearance of my teeth

FOR IMPLANT CONSULTATION PATIENTS ONLY

1. Upon completion of your implant treatment, you would expect the following:

Esthetics (choose one)

☐ A beautiful, white smile- everyone notices
☐ A natural smile- healthy looking, people will notice I look better but may not know why
☐ The appearance of my smile is not that important

Function

My expectation of full chewing upon completion (circle):

Soft Foods Only 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 All Foods

2. Upon completion of implant treatment:

☐ It's important that any tooth replacement is not able to be removed (fixed)
☐ Removable teeth like a partial or denture are okay, as long as they are comfortable

PATIENT CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Signature _____ Date _____

PRE-AUTHORIZED CARD ON FILE FORM

I authorize Towne Centre Family Dental to keep my signature on file and to charge my credit/debit card account as indicated below.

- Copayments, Deductibles, Coinsurance, and Product/Supplement fees due at time of service
- Balance of charges not paid by the insurance or by myself after 30 days of receipt of explanation of benefits

Card Information:

Card Type (Circle): VISA / MASTERCARD / AMEX
Name on Card: _____ Billing Zip Code: _____
Card Number: _____
Expiration Date: _____ CVV: _____
Cardholder Signature: _____

Please list anyone other than the cardholder who is authorized to use this credit/debit card.
Name(s):

I understand this credit/debit card will be kept on file and will remain in effect until the expiration of the credit card account unless otherwise stated. This credit card on file may be removed at any time by submitting a written request. A new form must be filled out if any information such as credit/debit card number or authorized users is amended. I agree to pay the cost for any returned or challenged payments.

Signature _____ Date _____

PHOTOGRAPHY RELEASE

I, _____ hereby authorize Dr. Albert Internoscia, associates, and staff to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care and may be used for education purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, videotapes, DVDs, television), and professional publications (dental magazines and journals).

I further understand that if these photographs, slides, and/or videos are used in any publication or as part of a demonstration, my full name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these materials.

Signature _____ Date _____