PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT)

Home Phone _____ Cell Phone _____ Email _____

Patient _____
Last Name First Name Initial

Street Address _____ City _____ State _____ Zip _____

Sex □ M □ F Age _____ Birth date _____

□ Single □ Married □ Widowed □ Separated □ Divorced □ Child

Employer/School _____ Occupation _____

Employer/ School Address _____ Phone Number _____

Whom may we thank for referring you? _____

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

Who is responsible for this account? _____ Relationship to Patient _____

Responsible Party Birth date _____ Soc. Sec. # _____

Name of Dental Insurance Company _____

Subscriber ID # _____ Group ID # _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

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

□ Anemia	□ Cortisone Treatments	□ High Blood Pressure	□ Sinus Problems
□ Arthritis, Rheumatism	□ Cough, Persistent	□ HIV/AIDS	□ Shortness of Breath
□ Artificial Heart Valves	□ Cough up Blood	□ Jaw Pain	□ Skin Rash
□ Artificial Joints	□ Diabetes	□ Kidney Disease	□ Stroke
□ Asthma	□ Epilepsy	□ Liver Disease	□ Swelling of Feet or Ankles
□ Back Problems	□ Fainting	□ Mitral Valve Prolapse	□ Thyroid Problems
□ Blood Disease/Transf.	□ Headaches	□ Pacemaker	□ Tobacco/Vape Habit
□ Cancer	□ Heart Murmur	□ Radiation Treatment	□ Tonsillitis
□ Chemical Dependency	□ Heart Problems	□ Respiratory Disease	□ Tuberculosis
□ Chemotherapy	□ Hemophilia	□ Rheumatic Fever	□ Ulcer
□ Circulatory Problems	□ Hepatitis	□ Scarlet Fever	□ Venereal Disease

(Women) Are you pregnant? □ YES □ NO Nursing? □ YES □ NO Taking Birth Control Pills? □ YES □ NO

Please list any medications you are currently taking: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? □ YES □ NO

If yes, what? _____

Are you under the care if a physician? □ YES □ NO For what condition? _____

_____

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 Jersey Dental Group or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

(SEE OTHER SIDE)

OFFICE GUIDELINES

Jersey Dental Group is committed to providing all patients with exceptional service and quality care. Please review our office guideline and sing/date below. Thank You.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment we require a **24 hour notice**. You may leave a message at any time, within 24 hours, by calling 609-835-4043. There will be a $30 fee assessed for every appointment missed without 24 hour notification.

We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first offense. We record all appointments, cancellation and no show appointments and discourage repeat abuse of our scheduling guidelines.

Financial Obligation/ Payment Guidelines

Patients with dental benefits: As a courtesy to our patients who have dental benefits, we are happy to file your claims electronically from our office. Please understand that it is your responsibility to know your specific plan/policy coverage. Your dental benefits may cover more or less than we estimate. Therefore, your **ESTIMATED CO-PAY** will be collected at the time services are rendered. After we receive payment from your insurance we will send you a statement with any remaining balance.

Patients without dental benefits: Patients without dental benefits are required to pay in full at the time services are rendered.

Payment Plan Options

Jersey Dental Group offers payment plan options through care credit. Care credit offers interest free payment options along with extended payment plans. Log on to www.carecredit.com for more information. Brochures available upon request.

If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these policies. These policies will enable us to better serve the needs of all patients.

I have read and understand the above policies.

(Signature of Patient or Guardian)	*(Today's Date)*

JERSEY DENTAL
A Member of Jersey Dental Group
1900 Mount Holly Road, Suite 2C
Burlington, NJ 08016
609-835-4043

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed our used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPPA consent form; therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with, other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

This HIPPA Consent/Sharing was signed by (Signature) (Today's date)

_____

Relationship to patient (if other than patient)

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