East Hanover Family Dental

REGISTRATION AND HEALTH HISTORY

Date: _____

First Name: _____ M.I. ____ Last Name: _____ ☐ male ☐ female Date of Birth: _____ (Enter as MMDDYYYY) Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____ (Do NOT include dashes or spaces)

Email Address: _____ Emergency Contact: _____

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Family Physician: _____ Phone#: _____

Dental Insurance Carrier: _____ ID#: _____ Group #: _____

☐ Check this box ***ONLY*** if the Insured person *(the person receiving dental service)* is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS#: _____ (Do NOT include dashes or spaces) Insured's Date of Birth: _____ (Enter as MMDDYYYY)

Relationship to Insured: _____

Employer of Insured: _____ ☐ Full-time ☐ Part-time ☐ Retired Phone#: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Who is financially responsible for this account? _____ Phone#: _____

Please select Y = Yes or N = No if you have any of the following conditions:

☐Y ☐N - Rheumatic Fever	☐Y ☐N - Thyroid Disease	☐Y ☐N - Seizure Disorder
☐Y ☐N - Heart Disease	☐Y ☐N - Anemia	☐Y ☐N - Kidney Disease
☐Y ☐N - Heart Murmur (or MVP)	☐Y ☐N - Asthma	☐Y ☐N - Venereal Disease
☐Y ☐N - High Blood Pressure	☐Y ☐N - Diabetes	☐Y ☐N - Bleeding Problems
☐Y ☐N - Tuberculosis	☐Y ☐N - Are you nursing	☐Y ☐N - Cancer
☐Y ☐N - Use Oral Contraceptives	☐Y ☐N - Might you be pregnant	☐Y ☐N - Aids/HIV
☐Y ☐N - Artificial Joint / Heart Valve	☐Y ☐N - Hepatitis Type: ☐A ☐B ☐C	☐Y ☐N - Eating Disorders
☐Y ☐N - History of Endocarditis	☐Y ☐N - Radiation Therapy: Head / Neck	☐Y ☐N - History of HPV

Other conditions not listed: _____

Are you allergic to latex, soy, egg, milk, dairy or nuts products? _____

List any antibiotics, anesthetics or other drugs you are allergic to: _____

List all prescription/OTC medications, vitamins and/or supplements you are presently taking: _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your temporomandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? ☐ Yes ☐ No If yes, why? _____

Do you take aspirin on a daily basis? ☐ Yes ☐ No If yes, why? _____

Are you under a physician's care presently? ☐ Yes ☐ No If yes, why? _____

Have you ever been a drug or substance abuser? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to EHFD unless otherwise indicated.

Signature: _____ **Date:** _____

*Your signature indicates you have received a copy of the HIPAA law.

East Hanover Family Dental

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐ Yes ☐ No
If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? ____ time(s) a _____ How often do you floss? ____ time(s) a _____

What type of brush do you use? ☐ Manual ☐ Powered

Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No If yes, what part? _____

Which foods cause you twinges of pain: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No Do your jaws ever feel tired? ☐ Yes ☐ No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? ☐ Yes ☐ No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): _____

Would you like to have whiter teeth? ☐ Yes ☐ No

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight using Dental Imaging and Digital Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? ☐ Yes ☐ No **If yes, please select all that apply:**

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

East Hanover Family Dental

FINANCIAL MENU

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) Prepayment in Full

For any treatment over $2000, a prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

D) CareCredit

Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no up-front costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

Interest of 1.5% per month will be charged on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all feed for services rendered. We will gladly assist you in any way we can.

I understand that if I become delinquent on my account, my account will be turned over to a collection agency and I will subsequently be reported to the credit bureaus. In case of total default I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

After your dental insurance has paid for dental services rendered at EHFD, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization, or you may need to pay your entire balance up-front.

Credit Card: (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex ☐ CareCredit

Card#: _____ Expiration Date: _____ CVV #: _____

(Do NOT include dashes or spaces) *(Enter as MMYY)*

Card Holder Signature: _____

Billing Address: _____ State: _____ Zip: _____

I certify that I have read, fully understand, and accept the above financial policy.

Signature: _____ **Date:** _____

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Family Dental

APPOINTMENT AGREEMENT

At the East Hanover Family Dental, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 business hours, you will be subject to a $75 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at the East Hanover Family Dental and agree to the "broken appointment" fee should I not give proper notification.

Signature of Patient or Responsible Party **Date**