PATIENT INFORMATION (Please Print)

Title: _____ **First Name:** _____ **MI:** ____ **Last Name:** _____

Birthdate: _____ **Soc. Sec.:** _____ **Gender:** ◯ Male ◯ Female

Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phones: **Phone:** _____ **Alt. Phone:** _____

Phone 3: _____ **Mobile:** ( ) - _____ **Email:** _____

Employer: _____ **Phone:** ( ) - _____ **Occupation:** _____

Referred By: _____ _____ _____ **General Dentist:** _____ _____

Have you been seen in this practice before today? ◯ Yes ◯ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ **First Name:** _____ **MI:** ____ **Last Name:** _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ **Soc. Sec.:** _____

Address: _____ **Apt./Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phones: **Phone 1:** _____ **Phone 2:** _____

Phone 3: _____ **Mobile:** ( ) - _____ **Email:** _____

Employer: _____ **Phone:** ( ) - _____ **Occupation:** _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ **Phone:** _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ **Soc. Sec.:** _____

Subscriber #: _____ **Sex:** ◯ Male ◯ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ **Phone:** _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ **Soc. Sec.:** _____

Subscriber #: _____ **Sex:** ◯ Male ◯ Female

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of David M Book DMD Date

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Today's date: _____ Date of Birth: _____

MEDICAL HISTORY

Name of Physician: _____ Phone#: _____ Date of last visit: _____

Emergency contact - Name: _____ Phone #: _____

Your current physical health is: □ Good □ Fair □ Poor

Have you ever had any serious operations? □ Yes □ No If yes, please explain _____

Are you currently under the care of a physician? □ Yes □ No Please explain: _____

Please CIRCLE if you have been treated for or told that you have:

Abnormal bleeding.....Anemia.....Blood Disorders.....Blood Transfusion.....Hemophilia..... ARC, AIDS or HIV+

Arthritis.....Asthma or Hay Fever .....Cancer/Tumor.....Chemo/Radiation therapy.....Kidney/Liver Disease.....Ulcers/Colitis

Diabetes.....Glaucoma.....Hepatitis /Jaundice.....Emphysema.....Tuberculosis.....Difficulty Breathing/Lung Problems

Congenital Heart Defect.....High/Low Blood Pressure.....Heart Attack .....Heart Murmur.....Heart Surgery

Mitral Valve Prolapse.....Pacemaker..... Prosthetic Heart Valve.....Rheumatic Fever.....Prosthetic (artificial) Joints

Drug Addiction.....Epilepsy/Seizures.....Fainting spells.....Severe/Frequent Headaches.....Stroke/CVA.....Venereal Disease

Osteoporosis ……

For the following questions, CIRCLE Y or N, whichever applies:

Y	**N**	Have you experienced unexplained weight loss?	**Y**	**N**	Do you experience shortness of breath?
Y	**N**	Have you ever had a reaction from anesthetic?	**Y**	**N**	Do you smoke or use smokeless tobacco?
Y	**N**	Do you drink alcoholic beverages?	**Y**	**N**	Have you had a prolonged cough?
Y	**N**	Do you take a daily dose of Aspirin?	**Y**	**N**	Do you bruise easily?
Y	**N**	Is extreme thirst a problem?	**Y**	**N**	Do your ankles swell?
Y	**N**	Do you sweat at night or get cold sweats?	**Y**	**N**	Do you get persistent swollen neck glands?
Y	**N**	Have you ever had a major operation?	**Y**	**N**	Have you ever had pain in your heart/chest?
Y	**N**	Have you ever taken any diet control medications such as Fen Phen?			

Do you have allergies? If yes, please fill out following:

Check if you are allergic to or have had problems with the following:

□ Penicillin ; □ Codeine ; □ Erythromycin; □ Tetracycline; □ Local injected anesthetics; □ Non gold jewelry; □ Latex

□ Other _____

Do you take any medications? If yes, please fill out following:

List any prescription or over the counter medications which you are taking:

Name of Medication:	Amount taken:	How often:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WOMEN ONLY

Please answer the following:

Are you pregnant? **Y N** If yes, list due date _____ ; Are you presently nursing? **Y N**

Do you take oral contraceptives? **Y N** If yes, please list name and dosage _____

I authorize my insurance company to pay to Dr. David M. Book all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. David M. Book to release all information necessary to secure the payment of benefits.

I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company. I understand that a 1.5% interest fee will be added per month for outstanding balances if there is no payment received within 30 days. I understand that a $20 fee will be added for accounts that go to collections.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice (e.g. appointments)

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Date: _____ Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Informed Consent for Endodontic Procedures

I. Recommended Treatment

I hereby give consent to Dr. Book to perform Endodontic Procedures on me or my dependent, and any such additional procedure(s) that may be considered necessary based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Discussion of Treatment

The Recommended Treatment works by removing bacteria from the hollow space inside the tooth, and by sealing off the inside of the tooth to prevent re-infection. Although the Recommended Treatment has a very high success rate, it is a biological procedure and cannot be guaranteed. Occasionally, a tooth which has had root canal treatment may require **retreatment, additional surgery, or extraction.**

III.. Treatment Alternatives

Alternative methods of treatment have been explained to me, such as extraction of the involved teeth, or postponement of root canal therapy, but I wish to proceed with the Recommended Treatment described above.

IV. Risks and Complications

I understand that there are risks and complications associated with the administration of medications including anesthesia, and performance of the Recommended Treatment.

These potential risks and complications, include, but are not limited to, the following:

1. Instrument breakage in the root canal.
2. Inability to negotiate canals due to prior treatment or calcification.
3. Perforation to the outside of the tooth.
4. Irreparable damage to the existing crown or restoration.
5. Cracking or fracturing of the root or crown of the tooth.
6. ; Pain, infection and swelling.
7. Difficulty opening and closing.
8. Temporomandibular Dysfunction resulting in jaw pain.
9. Nerve injury resulting in temporary or permanent numbness, itching, burning or tingling of the lip, chin, tongue or teeth.
10. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

David M. Book, D.M.D.

277 U.S. Highway 206, Suite 206
Flanders, NJ 07836

Phone: (973) 598-1161

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

***x*_____**
***Date:*_____**