Welcome to Dr. Louis J. Feldman's Office

Date: _____
SS# _____

Patient Name_____
Last First Middle
Address
_____

_____
City State Zip
Home Phone (___) _____-_____ Cell (___) _____-_____ Email:_____

Sex ☐ Male ☐ Female Age _____ _____ Birthdate _____/_____/_____
☐ Married ☐ Single ☐ Minor

Employer _____ Employer Phone (_____) _____-_____
Employer Address
_____

Spouse's Name _____ Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home Phone (___) _____-_____ Work Phone (___) _____-_____

Whom may we thank for referring you? _____

Reason for visit today _____

Former Dentist _____ City/State _____
Date of your last dental visit _____ Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have ever had any of the following:

Bad Breath	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Burning Sensation on tongue	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to hot	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity to biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
Jaw Pain or tiredness	☐ Yes	☐ No			

How often do you brush? _____ How often do you floss? _____
Physicians name _____Date of last visit _____

Please make a mark on "yes" or "no" to indicate if you have had any of the following:

Aids/HIV	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Bleeding abnormality w/ extractions/surgery	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Special diet	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hepatitis Type _____	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Unexpected weight loss	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No

Women Only:

Are you pregnant?	☐ Yes	☐ No	Taking Birth Control Pills?	☐ Yes	☐ No
If yes, Due Date: _____			Are you nursing	☐ Yes	☐ No

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy name _____ Phone (_____) _____

ALLERGIES

☐Aspirin
☐Barbiturates (sleeping pills)
☐Codeine
☐Latex
☐Local Anesthetics (Epinephrine)
☐Penicillin
☐Sulfa Drugs
☐Other _____

Primary Dental Insurance

Name of Insured- _____SS# _____
Last First Middle

Insured's Date of Birth- _____/_____/_____ ID #- _____Group #- _____

Insured's Address
_____
Street City State Zip

Insured's Employer- _____Phone (____) ____-_____
Employers Address-_____
Street City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance plan name and address-
_____
_____
_____

Secondary Dental Insurance

Name of Insured- _____ SS# _____-_____-_____
Last First Middle

Insured's Date of Birth- _____/_____/_____ ID #- _____ Group #-_____

Insured's Address_____
Street City State Zip

Insured's Employer- _____Phone (_____) _____-_____

Employers Address- _____
Street City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance plan name and address-
_____
_____
_____

Consent for Services

As a condition of your treatment at our office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for cost incurred in their care and financial responsibilities on the part of each patient should be determined prior to treatment. All emergency dental services performed without previous financial arrangements must be paid in full at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patient's dental forms or assist in making collections from insurance company. A service charge of 1.5% per month (18.0 % annum) on any unpaid balance will be incurred on accounts exceeding 30 days, unless previously written financial agreements are satisfied. Any account referred to a collection agency will be subject to a $50 surcharge. All returned checks will be subject to a $25 service charge. Appointments missed or broken without 24 hours notice will be subject to a $25 surcharge. I understand that the fee estimate listed for this dental treatment can only be extended for a period of 3 months from the date of the patient examination. In consideration for the dental services rendered to me, at my request, by the Doctor, I agree to pay for said services to said Doctor or his assignee at the time services are rendered or within 5 days of billing if credit shall be extended. I further agree to pay all costs related to the collection of my account and reasonable attorney fees if suit be instituted hereunder. I have read the above conditions and agree to their content.

X_____ **Date** _____

Signature

INFORMED CONSENT - GENERAL DENISTRY

Choosing among dentally reasonable treatment alternatives is a shared responsibility of dentists and patients. In the usual case, the dentist will recommend a course of treatment. While a patient often decides to adopt the recommendation, the ultimate decision concerning treatment is made by the patient; provided the choice is dentally reasonable. Under the law in New Jersey, a dentist is obligated to inform a patient of dentally acceptable treatment alternatives and their attendant probable risks and outcomes, and the costs relative to the treatment that is recommended and/or rendered, so a patient can make a decision that is informed. This form, together with our conversation about treatment alternatives, risks and outcomes, is intended to fulfill the Dentist's legal obligation to obtain informed consent.

1. Treatment Plan. The Dental Services to be provided could include but not be limited to the specific treatment options which will be explained to patient prior to treatment.

2. Changes in treatment plan. During the course of treatment, procedures many need to be added, expanded or changed because conditions are found that were not identified during examination and first were observed during the course of treatment. The most common include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges or implants. Permission is hereby given to inform the patient for acceptance to perform any additional or expanded dental services that the Dentist determines are necessary. Further, in the Dentist's discretion, I may be referred to a specialist for further treatment, the cost of which is my responsibility.

3. Drugs, Medications and Sedation. Drugs, medications or anesthesia/sedation can cause allergic and other reactions. Examples includes, but are not limited to, swelling, redness, itching, vomiting, diarrhea, numbness or tingling of the lip, gum or tongue (which in rare cases many be permanent) and also in rare cases, anaphylactic shock. Since they also may cause drowsiness and impair coordination or awareness, a motor vehicle or hazardous device should not be operated before full recovery is achieved. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days as well as those that have been prescribed by the Dentist that may result in continued or aggravated infection and pain and potential resistance to effective treatment. In addition, antibiotics can reduce the effectiveness of birth control pills.

4. Fillings. The most common conditions encountered with fillings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, nerve damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems and occasional allergic reactions to filling material.

5. Endodontic Treatment (Root Canal). Although root canal treatment to retain a tooth or teeth that otherwise need to be extracted is a very common dental procedure with a reported success rate of over 90%, there are some risks and complications. The most common include swelling, soreness, infection, bleeding, trismus (restricted jaw opening), numbness or tingling of the lip, gum or tongue (which in rare cases may be permanent), discoloration of adjacent teeth or soft tissue, perforation of the root, and fractures (splits) of the crown or root of the tooth or restoration. Occasionally, one of the delicate instruments used to perform a root canal may break in the tooth. A tooth that does not respond to root

canal therapy may require re-treatment, surgery or extraction. Once a tooth has received a root canal treatment, it tends to be more brittle and weak. To minimize the likelihood of a fracture, restoration with a crown is recommended. There is no guarantee that root canal treatment will save a tooth.

6. Crowns, Onlays/Inlays, Bridges, Veneers and Bonding. Sometimes, it is difficult or impossible to exactly match the color of artificial teeth or restorative materials with natural teeth. Although assistance will be provided by the Dentist, it is my responsibility to accept changes, if any, (including, for example, shape, size fit and color) before permanent cementation. After a temporary crown has been placed, it is essential to have the new crown cemented as soon as it is ready because the temporary crown could lead to decay, gum disease, infections, problems with the bite and loss of the tooth. Further, if there is a prolonged delay in placing the permanent crown, it may no longer fit properly.

I understand that I will discuss treatment, alternatives, risks, outcomes and costs with the Dentist and will have all my questions answered before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon alternatives, I consent to the treatment, subject to changes in treatment plan, as detailed above.

Patient/Guardian Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use, obtain, or disclose protected health information.
The notice contains a patient's rights section describing your rights under law. You ascertain by your signature, that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used, obtained, or disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. In addition, if at any point you provide us a written or video testimonial you are consenting to the use of that testimonial for marketing purposes. You have the right to revoke this consent in writing, signed by you, however such a revocation will not be retroactive.

By signing this form I understand that:

- Protected health information may be obtained, disclosed, and used for treatment, payment, or healthcare operation.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by:

_____

(PLEASE PRINT NAME)

Signature: _____ Date: _____

Witness: _____ Date: _____

The 5 Levels of Dental Care We Offer Our Patients

Dear Patient,

We understand that choosing a new dentist and dental health team is a challenge that may make you feel uncertain. Let us welcome you and share some insights about our patient care philosophy:

"Our purpose is to help people achieve the highest level of well-being appropriate for them and, in doing so, enhance the quality of their lives."

In other words, we will help you stay or become as healthy as you choose. This goal goes somewhat against our training because most dentists only tell you how healthy you ought to be. Instead, we will help you understand your dental health choices so you can make a free and informed decision regarding how you would like to use our practice. Here are five helpful levels to decide your stance on dental health.

Please circle the level of care you feel is most appropriate at this time.

Level 1: Look Your Best These people want to look their best at all times. They take pride in their teeth and know that their smile is one of the first things others notice about them. They have a **MASTER PLAN** to solve dental issues in the long term. They want a healthy mouth, a stunning smile and will do what it takes to maintain it.

Level 2: Complete Dentistry Our patients at this level choose to have a thorough examination. They also decide on a **MASTER PLAN** with the dental team to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease – not simply the effects – and want all dental treatments provided to support them into the future.

Level 3: Self-Care Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short-range in nature.

Level 4: Remedial Care Some people desire treatment only when something breaks or becomes uncomfortable. Generally, patients at this level expect a limited type of examination focusing on obvious problems. They usually want to correct immediate problems with as little effort and cost as possible.

Level 5: Urgent Care People in crisis with an emergency problem fit into this category. Some examples are pain, swelling, or bleeding. We see these types of urgencies as immediately as possible.

We hope you really think about your best level of care for now. However, many patients change levels as we grow in partnership with them. We are here to help you discover and decide upon your most comfortable level. Thank you for the opportunity to serve and provide the best dentistry for you.

To your health,
Louis J. Feldman, D.D.S.