A&M Dental Arts

## Patients Information

**Today's Date**_______________

Patient Name: ____________________________________________________________________ □Male □Female
**FIRST** **LAST**

Birth Date: ________/_________/_________ □Married □Single □Child □Other ________
Month Day Year

Social Security #: ________-______-________

Mobil/Cell ________________________ Phone (Home): ___________________ (Work): ___________________ Ext:_______

E-Mail:_____________________________________________________ Best time to call:_____________________________

**Home Address**: ________________________________________________________________________ Apartment#_______________________

Street

_____________________________________________________________________________________________________
City State Zip Code

Patient's relationship to insured: □Self □Spouse □Child □Other___________________

**Work Address**: _____________________________________________________________________________________________
Street City State Zip Code

**Who may we thank for referring you?** ____________________________________________

## Responsible Party/Insurance Information (Fill out if other than patient)

Name: ________________________________________________________________________________ □Male □Female
**FIRST** **LAST**

Birth Date: ______/_______/_______ □Married □Single □Child □Other ____ Social Security #: _______-______-______
Month Day Year

Mobil/Cell ________________________ Phone (Home): ___________________ (Work): ___________________ Ext:_______

Address: ____________________________________________________________________________________________
# Street Apartment # City State Zip Code

Insurance Plan Name and Telephone: _______________________________________________________________

Insured's Birth Date: _____________________ ID #: ________________________ Group #:____________________

Employer Name: ______________________________________________________________________________________


120 Route 33 West
Manalapan, NJ 07726
P (732) 414-2002

**Have you ever had any of the following? Please check those that apply**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS | | | Excessive Bleeding | | | Pacemaker | | |
| **Allergies** ______________ | | | Fainting | | | Psychiatric/Psychological Care | | |
| Anemia | | | Glaucoma | | | **Pregnancy** Due Dt:______ | | |
| Arthritis | | | Growths | | | Radiation Treatment | | |
| Artificial Joints | | | Hay Fever | | | Respiratory Problems | | |
| Artificial Heart Valve | | | H. I. V. Positive | | | Rheumatic Fever | | |
| Asthma | | | Head Injuries | | | Rheumatism | | |
| Blood Disease | | | Heart (Attack, Disease, Surgery) | | | Sinus Problems | | |
| Bruise Easily | | | Heart Murmur | | | Smoke/Chew Tobacco | | |
| Cancer | | | Hemophilia | | | Stomach Problems | | |
| Cold Sores/Fever Blisters | | | Hepatitis | | | Stroke | | |
| Contact Lenses | | | High Blood Pressure | | | Thyroid Problems | | |
| Cortisone Medication | | | Kidney Disease | | | Tuberculosis | | |
| Diabetes | | | Latex Sensitivity | | | Tumors | | |
| Diet (Special/Restricted) | | | Liver Disease | | | Ulcers | | |
| Dizziness | | | Mental Disorders | | | Venereal Disease | | |
| Emphysema | | | Mitral Valve Prolapse | | | Codeine Allergy | | |
| Epilepsy | | | Nervous Disorders | | | Penicillin Allergy | | |

**Allergic/Adverse Reaction To Medication or Any Substance, Please specify: ______________________________________________________**

**Have you ever had any complications following dental treatment? □Yes □No If yes, please explain:___________________________________**

Have you been admitted to a hospital or needed emergency care during the past two years? □Yes □No If yes, please explain: ______________

Are you now under the care of a physician? □Yes □No If yes, please explain:_____________________________________________________

Name of Physician: ______________________________________________________________________Phone:__________________________

Do you have any health problems that need further clarification? □Yes □No If yes, please explain: ____________________________________

Are you taking any medications? Purpose? Please list_______________________________________________________________________

**To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.**

I hereby authorize Dr. Singh and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Singh to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize Dr. Singh to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. **As a condition of your treatment by this office, financial arrangements must be made in advance.** The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. **All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.** In consideration for the professional services rendered to me or at my request, by Dr. Singh , I agree to pay the reasonable value of said services to Dr. Singh , or his assignee, at the time said services are rendered. Further, I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
**I have read the above conditions of treatment and payment and agree to their content.**

**X**_______________________________________________ Date: _____________ Relationship to Patient:__________________________
Signature of patient, parent or guardian

_______________________________________________ Date: _____________ Relationship to Patient: __________________________
Signature of guarantor of payment/responsible party

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# Payment, Financial, Insurance and HIPAA Information

We appreciate the opportunity to serve you. It is our intention to provide you with the finest care possible, while ensuring that you fully understand procedures, treatment, and payment expectations.

**We ask that all payments or co-payments be made at the time of service.** For your convenience Cash, Visa, MasterCard, Care Credit Financing are accepted. An estimate of your total fee will be reviewed and explained in detail to you at the time of your initial visit. If the insurance estimate is incorrect and patient should overpay we will gladly send a refund to the patient directly. We would rather send refunds then bills.

Insurance: Our office is happy to help you process your insurance. We will complete our portion of the claim form and mail it promptly at no charge. Difficulty obtaining insurance payment may occur, and **insurance payments CANNOT be guaranteed**. **Patient is solely and ultimately responsible for payment.**

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information ______________ **(*please initial*).**

***Scheduling Information***

Except in emergency situations, you can expect us to be on time for you, and we will appreciate the same courtesy. Your appointment time is tailored for you. If the need arises to reschedule your appointment, please provide us at least **2 business days' notice.** Without adequate notification, we will not be able to give your reserved time to another patient in need of dental care. There is a **$50.00 broken appointment fee ($75 for Saturday)** for every hour of the scheduled appointment. This fee covers the room preparation charge and the idle time of the Doctor, hygienist, and dental assistant who were on duty to provide your personalized care. If your schedule does not permit you to plan in advance, we might suggest placing you on our list of patients to call on a short notice basis.

If you have any questions, we would appreciate your prompt inquiry.

I have read and understand the above information _______________ **(*please initial*).**

***Notice of Privacy Practices – Acknowledgement***

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Office Manager.
Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

| | | |
|---|---|---|
| ________________________________ | ________________________ | _______________ |
| Patient or legally authorized individual | Signature | Date |
| ________________________________ | ________________________ | _______________ |
| Printed Name if signed on behalf of patient | Relationship (parent, etc.) | Patient Name |

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