KINGSTON IMPLANTS AND SMILES

SANDEEP TEOTIA, DMD MSC DICOI & DAVID YOUNG, DMD DICOI

PATIENT REGISTRATION

Patients First Name: _____ Last Name: _____ Middle Initial_____

Preferred Name:_____

Patient Is: _____ Policy Holder

_____ Responsible Party

RESPONSIBLE PARTY (if someone other than the patient)_____

First Name:_____ Last Name: _____ Middle Initial:_____

Address:_____ Address 2: _____

City, State, Zip: _____ Page:_____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular_____

Birth Date_____ Soc Sec: _____ Drivers Lic:_____

_____ Responsible Party is also a Policy Holder for Patient _____ Primary Insurance Policy Holder _____ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address:_____ Address 2: _____

City:_____ State:_____ Zip: _____ Pager_____

Home Phone:_____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: _____ Male _____ Female Marital Status:_____ Married Single Divorced _____ Separated Widowed

Birth Date: _____ Age:_____ Soc. Sec:_____ Drivers Lic:_____

E-mail: _____ _____ I would like to receive correspondences via e-mail.

SECTION 2

Employment Status: _____ Full Time _____ Part Time Retired

Student Status: _____ Full Time _____ Part Time

Medicaid ID: _____ Pref. Dentist:_____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

SECTION 3

Family Member Ph #: _____

Transportation #: _____

Care Credit #:_____

Credit Card #:_____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

Insured Soc. Sec: _____ Insured Birth Date:_____

Employer _____ Ins. Company _____

Address: _____ Address _____

Address 2: _____ Address 2 _____

City,State.Zip:_____ City,State,Zip _____

Rem. Benefits: $_____ Rem Deduct: $_____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer _____ Ins Company _____

Address: _____ Address_____

Address 2: _____ Address 2 _____

City.State.Zip: _____ City,State,Zip _____

Rem. Benefits: _____ $_____ Rem. Deduct: _____ $_____

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MEDICAL HISTORY

Patient's First Name: _____ Last Name _____ Middle Initial _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physician's care? ___Yes ___No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ___Yes ___No If yes, please explain: _____

Have you ever had a serious head or neck injury? ___Yes ___No If yes, please explain: _____

Are you taking any medication pills or drugs? ___Yes ___No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ___Yes ___No _____

Are you on a special diet? ___Yes ___No _____

Do you use tobacco? ___Yes ___No _____

Do you use controlled substances? ___Yes ___No _____

Women: Are you

Pregnant/Trying to get pregnant? ___Yes ___ No Taking oral contraceptives? ____ Yes ____No Nursing? ____Yes ____No

Are you allergic to any of the following?

_____Aspirin _____ Penicillin _____Codeine _____Acrylic _____ Metal _____ Latex _____ Local Anesthetics

_____Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	___Yes ___No	Cortisone Medicine	___Yes ___No	Hemophilia	___Yes ___No	Renal Dialynis	___Yes ___No
Alzheimer's Disease	___Yes ___No	Diabetes	___Yes ___No	Hepatitis A	___Yes ___No	Rheumatic Fever	___Yes ___No
Anaphylaxis	___Yes ___No	Drug Addition	___Yes ___No	Hepatitis B or C	___Yes ___No	Rheumatism	___Yes ___No
Anemia	___Yes ___No	Easily Winded	___Yes ___No	Herpes	___Yes ___No	Scarlet Fever	___Yes ___No
Angina	___Yes ___No	Emphysema	___Yes ___No	High Blood Pressure	___Yes ___No	Shingles	___Yes ___No
Arthritis/Gout	___Yes ___No	Epilepsy or Seizures	___Yes ___No	Hives or Rash	___Yes ___No	Sickle Cell Disease	___Yes ___No
Artificial Heart Valve	___Yes ___No	Excessive Bleeding	___Yes ___No	Hypoglycemia	___Yes ___No	Sinus Trouble	___Yes ___No
Artificial Joint	___Yes ___No	Excessive Thirst	___Yes ___No	Irregular Heartbeat	___Yes ___No	Spina Bifida	___Yes ___No
Asthma	___Yes ___No	Fainting Spells/Dizziness	___Yes ___No	Kidney Problems	___Yes ___No	Stomach/Intestinal Disease	___Yes ___No
Blood Disease	___Yes ___No	Frequent Cough	___Yes ___No	Leukemia	___Yes ___No	Stroke	___Yes ___No
Blood Transfusion	___Yes ___No	Frequent Diarrhea	___Yes ___No	Liver Disease	___Yes ___No	Swelling of Limbs	___Yes ___No
Breathing Problem	___Yes ___No	Frequent Headaches	___Yes ___No	Low Blood Pressure	___Yes ___No	Thyroid Disease	___Yes ___No
Bruise Easily	___Yes ___No	Genital Herpes	___Yes ___No	Lung Disease	___Yes ___No	Tonsillitis	___Yes ___No
Cancer	___Yes ___No	Glaucoma	___Yes ___No	Mitral Valve Prolapse	___Yes ___No	Tuberculosis	___Yes ___No
Chemotherapy	___Yes ___No	Hay Fever	___Yes ___No	Pain in Jaw Joints	___Yes ___No	Tumors or Growths	___Yes ___No
Chest Pains	___Yes ___No	Heart Attack/Failure	___Yes ___No	Parathyroid Disease	___Yes ___No	Ulcers	___Yes ___No
Cold sores/Fever Blisters	___Yes ___No	Heart Murmur	___Yes ___No	Psychiatric Care	___Yes ___No	Venereal Disease	___Yes ___No
Congenital Heart Disorder	___Yes ___No	Heart Pace Maker	___Yes ___No	Radiation Treatment	___Yes ___No	Yellow Jaundice	___Yes ___No
Convulsions	___Yes ___No	Heart Trouble/Disease	___Yes ___No	Recent Weight Loss	___Yes ___No		

Have you ever had any serious illness not listed above? ____Yes ____No If Yes Please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Comments _____

_____

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

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ADULT DENTAL HISTORY

Patient's First Name: _____ Last Name: _____ Middle Initial _____ Date of Birth _____

				COMMENTS
1.	Purpose of initial visit _____			
2.	Are you aware of any problems? _____		___Yes___No	
3.	How long since your last dental visit? _____			
4.	What was done at that time? _____			
5.	Previous dentist name: _____			
	Address: _____	Telephone # _____		
6.	When was the last time your teeth were cleaned? _____			
7.	Have you made regular visits? _____		___Yes___No	
	How often? _____			
8.	Were dental x-rays taken?		___Yes___No	
9.	Have you lost any teeth or have any teeth been removed?		___Yes___No	
	Why? _____			
10.	Have they been replaced?		___Yes___No	
11.	How have they been replaced?			
	a. Fixed Bridge	When? _____		
	b. Removable Partial Denture	When? _____		
	c. Removable Full Denture	When? _____		
	d. Implant	When? _____		
12.	Are you unhappy with the replacement?		___Yes___No	
	If yes, explain _____			
13.	Would you like to know about permanent replacements?		___Yes___No	
14.	Have you ever had any problems or complications with previous dental treatment?		___Yes___No	
15.	Do you clench or grind your teeth?		___Yes___No	
16.	Does your jaw click or pop?		___Yes___No	
17.	Have you experienced any pain or soreness in the muscles of your face or around your ear?		___Yes___No	
18.	Do you have frequent headaches, neckaches, or shoulder aches?		___Yes___No	
19.	Does food get caught in your teeth?		___Yes___No	
20.	Are your teeth sensitive to: ___Hot? ___Cold?	___Sweet? ___Pressure?		
21.	Do your gums bleed or hurt?			
	When? _____			
22.	How often do you brush your teeth? _____	When?		
23.	Do you use dental floss?	___Yes___No	How often? _____	
24.	Are any of your teeth loose, tipped, shifted or chipped?		___Yes___No	
25.	Are you unhappy with the appearance of your teeth		___Yes___No	
26.	Do you feel your breath is offensive at times?		___Yes___No	
27.	Have you ever had gum treatment or surgery?		___Yes___No	
	What type? _____			
	What part of your mouth? _____			
	When? _____			
28.	Have you had any orthodontic work?		___Yes___No	
29.	Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?		___Yes___No	
30.	Do you have any questions or concerns?		___Yes___No	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ **DATE** _____

DENTIST'S SIGNATURE _____ **DATE** _____

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4432 Route 27, CN 201, Kingston, NJ 08528

NOTICE OF PRIVACY PRACTICES
RESPONSBILE PARTY ACKNOWLEDGEMENT

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("Hipaa"),** I have certain rights to privacy regarding **my protected health information.** I understand that this information can and will be used to:

- ***Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.**
- ***Obtain payment from third-party payers.**
- ***Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read, and understand your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PLEASE NOTE:

This form is NOT a notice or acknowledgement of financial responsibility.

Who should fill this form out? Who is the "responsible party"
Patients over 18 years of age who are legally responsible for their own health information, OR The legal guardian (i.e., a parent or Power of Attorney) of a patient under 18 years of age or a patient over 18 years of age who is not legally responsible for their own health information.

Printed Name of Responsible Party:_____
Signature of Responsible Party:_____
Relationship of Responsible Party to Patient Self Parent Other
Today's Date_____
Printed Name(s) of Additional Person(s) with whom to share Health Information, and their relationship to person or patient_____

Office use only
I was unable to obtain the Responsible Party's Signature on this Notice of Privacy Practices
Today's Date:

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The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of each visit to our office, unless prior arrangements have been made. We would be happy to discuss a third party payment arrangement made thru care credit, which allows you the option of paying over time with zero interest. We are happy to assist you thru this process and figure an option that fits within your budget. We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visits total bill. Please bring cash, check, or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate. Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member, or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month, in addition to a $5.00 monthly billing fee per statement. Delinquent balances over 90 days old will be referred to Collection agency. All referred accounts are marked "Inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance must be paid in full. A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear, must be paid in cash, or by Visa, MasterCard, or Discover. We realize your time is valuable and do our very best to respect that. Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 24 hours advance notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $55.00 for repeatedly missed appointments without proper notification. We are always here to answer any of your financial questions, and work with you in any way we can; please don't hesitate to ask any of our qualified team members!

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorized release of any information concerning myself or my child's healthcare, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning myself or my child's health care, advise and treatment to another dentist.

I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Patient's or Guardian's Signature_____ **Date**_____