

## PATIENT REGISTRATION

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_

Emergency Number: \_\_\_\_\_

Spouses Name: \_\_\_\_\_

### 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: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

### 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: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Date Created: \_\_\_\_\_

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 now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

Other?  If yes \_\_\_\_\_

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed  Yes  No If yes \_\_\_\_\_

Comments:

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.

Signature of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

X

Dr. Alyssa S. Bernstein  
560 St. Georges Ave.  
Rahway, NJ 07065

**INFORMED CONSENT**

1. I, \_\_\_\_\_ hereby authorize and direct the dentist, ALYSSA S. BERNSTEIN, D.M.D. and/or dental auxiliaries of her choice to perform the following dental treatment including the use of any necessary or advisable local anesthesia, radiographs (x-rays), diagnostic aids (impressions), photographs, etc.
  - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
  - B. Application of plastic sealants to the grooves of the teeth.
  - C. Treatment of diseased or injured teeth with fillings, endodontics and/or crowns.
  - D. Replacement of missing teeth with dental prostheses, i.e., dentures, crowns, implants, etc.
2. I understand that there are risks involved in dental treatment and hereby acknowledge that these risks will be explained to me and that I will have an opportunity to ask questions regarding the treatment and the risks so that I may understand the same.
3. I agree that the success of the treatment requires that all post-operative instructions be followed and that regular office visits as scheduled by the dentist be maintained.
4. I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary for my oral health and well-being.
5. There are possible risks and complications associated with the administration of local anesthesia. The most common of these are swelling, pain, bleeding, vomiting, bruising and numbness of the lips, cheeks and gums, allergic reactions, hematoma, fainting, lip or cheek biting resulting in the ulceration and infection of the mucosa. I also understand that many prescription medications may have risks associated with them as well. I further understand that there are potentially greater risks, such as respiratory and cardiovascular collapse.

I hereby state that I have read and understand this consent and that I have the right to be provided answers to all of my questions.

I also understand that I am financially responsible for all work performed by or under the direction of Dr. Alyssa Bernstein.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Dr. Alyssa S. Bernstein  
560 St. Georges Ave.  
Rahway, NJ 07065

Date \_\_\_\_\_

## FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, checks, MasterCard, Visa, Amex, and Care Credit\*. The balance on your account is past due if not paid by the end of the month.

### Payment options if you have no insurance:

1. We offer convenient payment options by cash, checks, Master Card, Visa, Amex, and Care Credit\*.
2. On treatment involving laboratory fees (crown and bridge, dentures, etc.) 50% of the treatment fee is required on the preparation day and the balance on the completion date.

### Payment options if you have insurance:

1. You are required to pay your deductible or any other co-pays the day services are rendered.
2. If we do not participate with your insurance; you are required to pay the full fee for treatment rendered at the time of service. As a courtesy we will submit the claim to your insurance company and have reimbursement sent to you.
3. On extensive treatment (crown, bridge, etc.) 50% of your co-pay is required at the time of preparation and the balance on the completion date.

INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. All charges are your responsibility from the date of service, while the filing of insurance claims is a courtesy that we extend to our patients. In the case the insurance company fails to pay their portion and we have made every attempt to appeal their denial the patient is responsible for their insurance company's portion of the payment.

BILLING: If you have a balance on your account, we will send you a monthly bill showing a description of treatment, any charges, any credit, and any finance charge. There is a billing fee of \$1.50 per bill.

FINANCE CHARGE: Balances older than 30 days will be subject to a finance charge at the monthly rate of 1 ½% or an annual percentage rate of 18%.

MISSED APPOINTMENT FEE: A charge of \$30 will be made for broken appointments and appointments cancelled with less than 24 hours notice.

RETURNED CHECKS: There is fee of \$25 for any checks returned by the bank.

COLLECTIONS: If we have to refer you past due account to a lawyer or a collection agency, you shall be responsible for all attorney fee and all court fees.

By signing this policy you agree that you have read and understand all the terms of this policy.

Patient (or patient's guardian) \_\_\_\_\_

Signature: \_\_\_\_\_

\*subject to credit approval

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_