THE DENTISTRY CO. BRIELLE | OCEAN

421 Higgins Ave, Brielle, NJ 08730 ▪ P: (732) 528-6336 ▪ info@brielledentistryco.com
240 Monmouth Rd, Oakhurst, NJ 07755 ▪ P: (732) 531-3773 ▪ info@oceandentistryco.com

Date _____

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Date of Birth _____ Age _____

Social Security No. _____ Gender ☐ M ☐ F Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Whom may we thank for **referring** you? _____

In an **emergency**, who should be notified? Please list Name(s), Phone Number, & Relationship

_____

_____

EMPLOYMENT (the following is for): ☐ The Patient ☐ The person responsible for payment ☐ Both ☐ NA

Occupation _____ Employer _____ Phone _____

Employer's Address _____

PRIMARY INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____ SS# _____ DOB _____

Name of Employer _____ Employer Address _____ State _____

Insurance Company _____ Insurance ID # _____ Group # _____

Insurance Phone # _____ Insurance Address _____

SECONDARY INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____ SS# _____ DOB _____

Name of Employer _____ Employer Address _____ State _____

Insurance Company _____ Insurance ID # _____ Group # _____

Insurance Phone # _____ Insurance Address _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that the dentist will use this information to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will immediately inform the dentist.

_____ _____

Print Patient's Name *Today's Date*

_____ _____

Patient's or Patient's Representative's Signature *Relationship*

THE DENTISTRY CO. BRIELLE | OCEAN

421 Higgins Ave, Brielle, NJ 08730 ▪ P: (732) 528-6336 ▪ info@brielledentistryco.com
240 Monmouth Rd, Oakhurst, NJ 07755 ▪ P: (732) 531-3773 ▪ info@oceandentistryco.com

Today's Date_____ Print Patient' Name _____ DOB _____

Medical Health History

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. Indicate which of the following you have had or have at present. Checking the box will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Pre-Med - Amoxicillin	☐ Pre-Med - Clindamycin	☐ Pre-Med - Other	☐ Allergy to metal post used in RCT
☐ Allergy - Asprin	☐ Allergy - Codeine	☐ Allergy - Penicillin	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Erythro	☐ Allergy - Sulfa	☐ Arthritis
☐ Alzheimer's/Dementia	☐ Allergy - Other	☐ Anemia	☐ Blood Disease
☐ Artificial Joints	☐ Asthma	☐ Autoimmune Disease	☐ Dizziness/Fainting
☐ Blood Thinners	☐ Cancer	☐ Diabetes Type 1 or 2	☐ GERD/Reflux/Ulcer
☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Factor V Deficiency (mild/mod bleeding risk)	☐ HIV/AIDS
☐ Glaucoma/Eye Disease	☐ Gout	☐ Heart Disease	☐ Heart Murmur/Defect
☐ Head/Neck/Jaw Injury	☐ Hearing Loss/Aids	☐ Jaundice	☐ Kidney Disease
☐ Hepatitis A/B/C	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ NITROUS OXIDE for all procedures
☐ Liver Disease	☐ Mental Disorders	☐ Radiation/Chemo	☐ STD/HPV
☐ Nervous Disorders	☐ Pacemaker/Stents	☐ Rheumatism	☐ Tuberculosis
☐ Respiratory Problems	☐ Rhumatic Fever	☐ Trigeminal Neuralgia	☐ Other:_____
☐ Sinus Problems	☐ Stroke	☐ Other:_____	
☐ Tumors/Growths	☐ Other:_____		

☐ Pregnant/Planning Pregnancy/Nursing ☐ Taking Birth Control ☐ Tobacco/Vaping Use

Please Clarify Medical Conditions, including due date if pregnant: _____

_____

Do you take antibiotic premedication for dental appointments? If Yes, please explain. ☐Yes ☐No _____

_____

Describe any current medical treatment or illnesses, recent hospitalizations & recent or upcoming surgery _____

_____

Are you taking any medications (prescription and non-prescription) If Yes, please list medications & dosage below ☐Yes ☐No

_____

_____

_____

_____

_____

Today's Date_____ Print Patient' Name _____ DOB _____

Medical Health History Continued

Name of physician and date of last physical exam: _____

_____

Name & phone number of preferred pharmacy: _____

_____

Dental Health History

What are some of your most immediate concerns about your dental health?_____

_____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number: _____

Date of most recent dental exam & xrays _____

Is there anything about the appearance of your smile that you would like to change?_____

_____

Indicate which of the following you have had or have at present. Checking the box will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Had complications from past dental treatment ☐ Had/have braces, orthodontic treatment ☐ Food gets trapped between any teeth ☐ You have difficulty chewing ☐ Your gums Bleed when brushing or flossing ☐ Experience gum recession ☐ You snore or wake up frequently in the night ☐ Have trouble getting numb ☐ You experience dry mouth ☐ You bleach or whiten your teeth ☐ You clench or grind your teeth	☐ Treated for gum disease or were told you lost bone around your teeth ☐ Had any teeth become loose on their own (without injury) ☐ Had any reactions to local anesthetic ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth ☐ Experience popping and/or clicking of your jaw joint ☐ You wear or have worn a bite appliance ☐ Notice an unpleasant taste or odor in your mouth ☐ Experience a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe_____

_____

By providing my signature below, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of x-rays and oral examinations.

_____ _____

Print Patient's Name *Today's Date*

_____ _____

Patient's or Patient's Representative's Signature *Relationship*

421 Higgins Ave, Brielle, NJ 08730 ▪ P: (732) 528-6336 ▪ info@brielledentistryco.com
240 Monmouth Rd, Oakhurst, NJ 07755 ▪ P: (732) 531-3773 ▪ info@oceandentistryco.com

Consent for Services and Financial Policy:

This is an agreement between **The Dentistry Co.** as creditor, and the Financially Responsible Party listed at the bottom of this agreement. In this agreement, the words "you", "your", and "yours" mean the responsible party listed. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to The Dentistry Co.

By executing this agreement, you are agreeing to pay for all services that are rendered.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to your account, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Payment Options- Without Dental Insurance

1. Payment is due on the day that treatment is scheduled and/or rendered with either Cash, Check, or Credit Card.
2. Payment is due on the day that treatment is scheduled and/or rendered by use of Care Credit, Proceed, Sunbit, Cherry, or any other approved 3rd party lender.

Payment Options- With Dental Insurance

1. Deductible and applicable co-payment is due on the day that treatment is scheduled and/or rendered with either Cash, Check or Credit Card.
2. Deductible and applicable co-payment is due on the day that treatment is scheduled and/or rendered by use of Care Credit, Proceed, Sunbit, Cherry, or any other approved 3rd party lender.
3. Payment may be made in full by you on the day that treatment is scheduled and/or rendered, and we will request your dental insurance carrier(s) send their benefit payment to you directly.

Insurance: Insurance is a contract between you and your insurance company. We will submit claims to your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefit amount. You agree to pay any portion of the charges not covered by your insurance company.

Additional Fees: Returned Check By Bank - $35

Delinquent Account Policy:

We'll take necessary steps to collect debt due by you. If we refer your account to a collection agency, you agree to pay all collection costs incurred. If we refer collection of the balance to an attorney, you agree to pay all attorney fees that we incur plus all court costs. You waive confidentiality with understanding and acknowledge that if your account is submitted to an attorney, collection agency, court litigation, or your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Cancellation Policy:

We kindly request a minimum of 48 hours' advance notice for any appointment changes or cancellations. Any cancellations made outside of the 48-hour window will incur the following charges:

1. A charge of $50 will be applied for any cancellation in the hygiene schedule (including cleanings and preventive appointments)
2. A charge of $100 per hour will be applied for cancellations of scheduled treatment in the doctor's schedule.

Please note that we reserve the right to waive these charges at our discretion. We understand that unforeseen circumstances may occur, and we appreciate your understanding and cooperation in adhering to our cancellation policy.

I understand the above information & agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Print Patient's Name *Today's Date*

_____ _____

Patient's or Patient's Representative's Signature *Relationship*

THE DENTISTRY CO. BRIELLE | OCEAN

421 Higgins Ave, Brielle, NJ 08730 ▪ P: (732) 528-6336 ▪ info@brielledentistryco.com
240 Monmouth Rd, Oakhurst, NJ 07755 ▪ P: (732) 531-3773 ▪ info@oceandentistryco.com

Consent for Internet Communications:

I consent to The Dentistry Co. utilizing internet-based communication services to improve the quality and efficiency of my dental care. I understand that third party HIPAA compliant services may be used for appointment confirmations, reminders, and any other necessary communications related to my treatment. By providing my contact information and consenting to internet communications, I acknowledge and agree to receive appointment reminders, important updates, and facilitate necessary interactions through these services. I trust that the security and confidentiality of my personal information are prioritized, and that all communications will be conducted in compliance with applicable privacy regulations. I understand that I may opt out of these communications at any time.

Photo & Video Release:

I authorize The Dentistry Co., it's representatives, and employees the right to utilize photographs, videos, x-rays, or any other viewings of my care and treatment during or after its completion for the following purposes:

1. Use on the The Dentistry Co. websites

2. Use on The Dentistry Co.'s social media pages, including but not limited to Facebook, Instagram, and Twitter

I understand that my photographs, videos, and/or x-rays may be used solely for the purposes of displaying dental procedures, treatments, and outcomes. No personally identifiable information, including my name, will be shared in conjunction with these images. The Dentistry Co. will follow all applicable laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), to ensure the privacy and confidentiality of my health information.

☐ I have read the information above regarding use of photos, videos, an/or x-rays. I grant The Dentistry Co. permission to use any photos/videos/x-rays for the purpose of displaying dental procedures to the public

☐ I do not authorize The Dentistry Co. to use any photos/videos/x-rays for the purpose of displaying dental procedures to the public

HIPAA Acknowledgement:

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health information to the following individuals: (This information could include Name, Diagnosis, Test Results, Image and Account Information). Please list Name(s) & Relationship:

_____

_____

By providing my signature below, I attest that I have read, understand and agree to the above consents/policies. This consent shall be considered in effect until rescinded or revoked.

_____ _____

Print Patient's Name *Today's Date*

_____ _____

Patient's or Patient's Representative's Signature *Relationship*