

# W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.  
We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.

## DENTAL HISTORY

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (✓) yes or no if you have had problems with any of the following:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot    | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |
- How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

## MEDICAL HISTORY

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check (✓) yes or no whether you have had any of the following:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent            | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain   | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood               | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction                      | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                     | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease                                      | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                     | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                     | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse                              | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints       | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies               | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems                                   | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                     | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery                            | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches                    | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care                                   | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur                 | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss                          | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems               | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment                                | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | Describe _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease                                | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever                            | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes                       |  | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                    |  |  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure          |  |  |

Is patient currently taking any medications? If yes, list all:

\_\_\_\_\_

Does patient have drug allergies? If yes, list all:

\_\_\_\_\_

## AUTHORIZATION

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

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**

## NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of \_\_\_\_\_, 20\_\_ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA  
or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
*200 Independence Avenue, S.W.*  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

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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 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 complete description of the uses and disclosures of my health information. I understand that 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 Private 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.

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

Relationship to Patient: \_\_\_\_\_

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

Date \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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George A. Rooney, III D.M.D.  
Christopher J. Rooney, D.M.D.  
*Holmdel Executive Plaza*  
719 N. Beers St., Suite 2C  
Holmdel, New Jersey 07733

Agreement to Sign Over Dental Benefit Payment

In consideration of dental treatment to be rendered to me or my dependents, I agree to sign over every dental benefit payment issued to me for dental services performed by this office within ten business days after receipt from a Dental Service Corporation, Health Service Corporation or Dental Plan Organization, provided, however, if the amount owed to this office is less than the amount of the dental benefit payment, then only the balance owed shall be paid.

Dated: \_\_\_\_\_

Signature \_\_\_\_\_