

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

**Patient Information**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Last Name First Name

Nickname: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_  
City State Zip Code

Phone #'s: Home: \_\_\_\_\_ Parent Cell/Work: \_\_\_\_\_

**Referral Information**

How did you hear about us? \_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last Name First Name

Gender Identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_  
City State Zip Code

Phone #'s: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**Dental Insurance Information**

**Primary**

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
Last Name First Name

Name of Employer: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_ Do you have secondary coverage? \_\_\_\_\_

**Secondary**

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
Last Name First Name

Name of Employer: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

**In Case of Emergency Contact**

Name of Contact: \_\_\_\_\_  
Last Name First Name

Patient's Relationship to Contact: \_\_\_\_\_ Best Phone # to reach: \_\_\_\_\_

Reverse Side →

**Medical/Dental History (Check the boxes that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Hepatitis A, B, C, D, E | <input type="checkbox"/> Oral Herpes            |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Chemical Dependency    |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Autism                  | <input type="checkbox"/> Jaundice/Liver Disease |
| <input type="checkbox"/> Organ Transplant        | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Thumb/Finger Sucking   |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Blood Thinners         |
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Circulatory Problems   |
| <input type="checkbox"/> Thyroid Disease         | <input type="checkbox"/> Cancer/Leukemia         | <input type="checkbox"/> High Cholesterol       |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Radiation Treatment     | <input type="checkbox"/> Breathing Problems     |
| <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Respiratory Disease     | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Other: _____           |

**Does your child have any of the following? If yes please list, or explain**

Allergies to Anesthetics: \_\_\_\_\_

General Allergies: \_\_\_\_\_

Allergies to Medicine/Drugs: \_\_\_\_\_

Have you ever had an adverse reaction to any dental treatment? YES  NO

If yes please explain. \_\_\_\_\_

Are you allergic to latex? YES  NO

Does your Physician require you to take antibiotics prior to dental treatment? YES  NO

Are you under the care of a physician? \_\_\_\_\_

**Please List Medications/doses you are currently taking:**

- Name of Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_

Is there anything else we should know about your medical history? \_\_\_\_\_

\_\_\_\_\_

When was your child's last dental cleaning? \_\_\_\_\_

Is your child's water fluoridated? Yes  No

Does your child brush his/her teeth daily? Yes  No

**The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dentistry at South Brunswick and Your Insurance Plan – How They Work Together?  
Our Office Financial Policy**

The staff at Dentistry at South Brunswick is pleased that you have insurance assistance to help with the cost of your dental care. We would like to help you obtain the maximum use of your dental plan benefits. Please read the following information on our insurance claims process so that we can work together to ensure this assistance.

*Do You Accept My Insurance? How Much Will They Pay?*

We currently accept all private care insurance plans (plans that do not *require* you to select a dentist from a pre-determined list). We estimate your portion based on the most up-to-date information on your plan, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a “pre-treatment authorization” with your insurance company prior to treatment.

*I Thought I Paid My Portion But I Received A Bill. Why?*

We base the patient portion of your bill on our most current information on your dental plan, but there are many factors that can affect this estimate. There may be an individual or family deductible or you may have received treatment in another office which is not calculated into our database. Sometimes you may need to be referred to a specialist for care, which also is applied to your annual maximum benefits. Insurance companies do not notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

*Insurance Didn't Pay. Now What?*

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Dentistry at South Brunswick reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. It is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

*Financial Options*

Dentistry at South Brunswick requests payment in full for your portion (co-pay) at the time of service. We accept cash, check, MasterCard, American Express, Discover, and Visa. If you are in need of an extended finance option, we also work with Care Credit, Chase Healthcare Advance, and Capital One. They offer plans up to 24 months with no interest, depending on your treatment plan needs. Just ask our Financial Coordinator Jill and she will give you everything you need.

We welcome you and your family and look forward to helping you get the healthy, beautiful smile you’ve always wanted. If there is anything we can do to make your visits here more pleasant, please don’t hesitate to ask.

*I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dentistry at South Brunswick.*

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*Signature*

*Date*

*Reverse Side*      

# HIPAA Patient Information Update Form

## Practice Information

Dentistry At South Brunswick  
886 Georges Road, Monmouth Junction, NJ 08852  
Phone: 732-951-0099 Fax : 732-951-2323

## Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
\_\_\_\_\_

## Address Update (if applicable)

Street: \_\_\_\_\_

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

## Authorized Individuals

Please list anyone you authorize our office to discuss your dental treatment, appointments, or billing with:

| Name | Relationship | Phone Number |
|------|--------------|--------------|
|      |              |              |
|      |              |              |

I do **not** authorize anyone to receive my information

## Communication Preferences

Appointment Reminders:  Call  Text  Email

Billing/Insurance Questions:  Call  Text  Email

## Message Consent

- You may leave detailed messages
- You may leave appointment reminders only
- Do NOT leave messages

## Privacy Acknowledgment

I acknowledge that I have received or been offered a copy of this office's Notice of Privacy Practices and understand my rights regarding my protected health information.

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