Date: _____

Patient Information

Patient's Name: _____ DOB: _____
Last Name First Name

Nickname: _____ Gender: _____ Pronouns: _____ Marital Status: _____

Social Security #: _____-_____-_____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home: _____ Work: _____ Ext. _____

Cell: _____ Best Time to Call: _____

Referral Information

How did you hear about us? _____

Spouse or Responsible Party Information (If Different from above)

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)

☐ Artificial Heart Valve	☐ Hepatitis A, B, C, D, E	☐ Oral Herpes
☐ Artificial Joints	☐ AIDS/HIV	☐ Chemical Dependency
☐ Pacemaker/Defibrillator	☐ Sleep Apnea	☐ Jaundice/Liver Disease
☐ Organ Transplant	☐ Headaches	☐ Ulcer
☐ High Blood Pressure	☐ Sinus Problems	☐ Immunosuppressive
☐ Low Blood Pressure	☐ Back Problems	☐ Blood Thinners
☐ Heart Problems	☐ Hemophilia	☐ Circulatory Problems
☐ Heart Murmur	☐ Diabetes	☐ Breathing Problems
☐ Stroke	☐ Thyroid Disease	☐ Asthma
☐ Psychiatric Care	☐ Cancer/Leukemia	☐ Respiratory Disease
☐ Epilepsy	☐ Radiation Treatment	☐ Other: _____

Do you 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: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

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

_____

Do you grind your teeth at night or suffer from Jaw pain? _____

Women: Do you suspect that you are pregnant? YES ☐ NO ☐

Are you taking any Birth Control? YES ☐ NO ☐

Are you nursing? YES ☐ NO ☐

When was your last dental cleaning? _____

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: _____

Reverse Side ⟶

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.

_____

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: _____