MEDICAL HISTORY

Patient Name _____

Please check yes or no to all the following questions. Your answers are for our records only and are necessary to aid in your dental treatment. Your answers are strictly confidential.

Yes	No	General
[ ]	[ ]	Good Health
[ ]	[ ]	Currently under physician's care for an illness List illness_____
[ ]	[ ]	Serious illness or operation in the past year List illness or operation _____
[ ]	[ ]	Taking medications List all medications (including over-the-counter/ herbal supplements) and reason for medication _____ _____ _____
[ ]	[ ]	Taken Fosamax or any other biphosphate medication

Yes	No	Respiratory
[ ]	[ ]	Asthma Do you have an inhaler? Y___ N___
[ ]	[ ]	Emphysema
[ ]	[ ]	Lung Disease
[ ]	[ ]	Exposure to Tuberculosis
[ ]	[ ]	Sinus Trouble

Yes	No	Nervous System
[ ]	[ ]	Seizure Disorder/Epilepsy
[ ]	[ ]	Hyperactivity
[ ]	[ ]	Anxiety/Depression Disorder
[ ]	[ ]	Fainting Spells

Yes	No	Immune/Endocrine
[ ]	[ ]	Immune Deficiency/HIV
[ ]	[ ]	Thyroid Disorder
[ ]	[ ]	Diabetes
[ ]	[ ]	Arthritis

Yes	No	Cardiovascular
[ ]	[ ]	Heart Disease
[ ]	[ ]	Heart Attack When? _____
[ ]	[ ]	High Blood Pressure
[ ]	[ ]	Angina Do you carry Nitroglycerin? Y___ N___
[ ]	[ ]	Pacemaker/Defibrillator
[ ]	[ ]	Stent
[ ]	[ ]	High Cholesterol

Yes	No	Blood Disorders
[ ]	[ ]	Bleeding Disorder
[ ]	[ ]	Anemia
[ ]	[ ]	Required a Blood Transfusion When? _____ Why? _____

Yes	No	Abdominal & Other Disorders
[ ]	[ ]	Gastro Intestinal Disease
[ ]	[ ]	Stomach Ulcers
[ ]	[ ]	Gastric Reflux
[ ]	[ ]	Liver Disease
[ ]	[ ]	Hepatitis, Type? _____ When? _____
[ ]	[ ]	Kidney Disease
[ ]	[ ]	Cancer, Type? _____ Treatment Received _____

Yes	No	Premedication
[ ]	[ ]	Heart Murmur
[ ]	[ ]	Mitral Valve Prolapse with Regurgitation
[ ]	[ ]	Valve Replacement due to Rheumatic Fever
[ ]	[ ]	Joint Replacement When? _____
[ ]	[ ]	A/V Shunt for Renal Dialysis

Other Medical Condition(s) _____

Yes	No	Social Activities
[ ]	[ ]	Smoke/Chew Tobacco Amount per day _____
[ ]	[ ]	Drink Alcohol Amount per week _____
[ ]	[ ]	Recreational Drugs Type and last usage _____

Yes	No	Women
[ ]	[ ]	Pregnant Due Date _____
[ ]	[ ]	Nursing
[ ]	[ ]	Taking Birth Control Pills
[ ]	[ ]	Hormone Replacement Therapy

Yes	No	Are You Allergic To:
[ ]	[ ]	Penicillin
[ ]	[ ]	Sulfa
[ ]	[ ]	Erythromycin
[ ]	[ ]	Keflex
[ ]	[ ]	Other Antibiotics _____
[ ]	[ ]	Local Anesthetics/Topical Anesthetics
[ ]	[ ]	Aspirin, Reaction _____
[ ]	[ ]	Codeine
[ ]	[ ]	Other Medications _____
[ ]	[ ]	Latex
[ ]	[ ]	Any type of Metal _____

Physician's Name/Phone # _____
When was your last dental visit? _____
Any current problems/concerns with your teeth or mouth?
_____
_____

I state that I understand all of the information above and that all of my responses are true to the best of my knowledge. I also understand that I am to inform this office of any change in my medical history immediately when that change occurs. I understand that the administration of local anesthesia may cause an adverse reaction which may include, but is not limited to bruising, a faster heart beat, temporary or rarely, permanent numbness or muscle soreness.

_____

Signature: Patient/Parent/Guardian **Date**

Confirmation of your Dental Appointment

We have a new system in our office for confirming your dental appointments. You will receive a recorded message asking you to confirm your dental appointment. All we ask, is that you listen and follow the instructions to confirm your appointment.

We offer four options to confirm your dental appointment:

1. Home telephone – message will go out 2 days prior to appointment
2. Cell phone – same as above
3. E-Mail – message will be sent 5 days prior to your appointment
4. Text message – sent the day of your appointment
   You have to "OPT." into this by texting "GO to 71599"

Please check below which option you prefer. You can check all 4

Home___

Cell____ Please provide Cell Phone Number_____

E-Mail___ Please provide E-Mail Address_____

Text Message___

The office of Dr. Mark Birnbaum…..*Welcomes you!*

We value our patients and the relationships we have with them. In order to help us form long term relationships with our new patients we have put together a few questions that will help us get to know you. It will only take a few minutes and would be most helpful. Thanks!

1. What is most important to you about your teeth? (Rate each of the following using 3=extremely important; 2=somewhat important; 1=slightly important; 0=not important.)
___Esthetics-How your teeth look.
___Longer visits to get treatment done more quickly.
___Keeping your teeth for the rest of your life.
___Staying within a budget.
___Being as free of discomfort as possible.

2. Why did you choose our office?

3. If you could wave a magic wand and change one thing about the appearance of your teeth, what would it be?

4. What did you like about previous visits to the dentist?

5. Why did you decide to leave your last dentist?

6. How do you feel about your past dentistry? (Scale of 1-10 with 10 being the best score)

7. Rate the present condition of your mouth. (Scale of 1-10 with 10 being the best score)

8. Have you ever considered dental implants as a permanent replacement for any missing teeth?

9. If any major treatment is needed or important decision made concerning the health of your mouth, would you like to have someone with you at the consultation?

10. What would you like for us to know to help us make your visits more pleasant?

I authorize the use of my study models and/or photographs for lectures or publications by this office.

Signature_____ Date_____

The Financial Aspect of Your Dental Treatment

Our primary goal is to provide the patient with the highest quality dentistry available, using the latest techniques and materials to ensure long lasting, beautiful results. We realize that this needs to be accomplished while keeping your budget in mind. All costs for your dental care will be discussed in detail so you may plan and budget for your treatment.

INSURANCE- For those of you that have dental insurance, we will bill your carrier as a COURTESY TO YOU, with you paying the estimated copay at the time of service. We will assist in claims submissions to obtain payment for your treatment. However, in some instances your insurance company will only send payment directly to you. If that is the case, we ask that you pay in full for your treatment at the time it is performed, and we will be glad to submit the paperwork to your insurance carrier for your direct reimbursement.

We will attempt to estimate how your insurance company will pay for your dental services, but we have no way of knowing exactly what they will pay until the claim is ultimately paid. There is no way we can guarantee what your insurance will pay. Please be advised – when your carrier is to pay us directly and if that payment is not received within 90 days of our submitting the claim, that dollar amount will automatically become your responsibility. This amount will be billed to you and is due upon receipt of a statement.

APPOINTMENTS-We will make every effort to schedule your appointment at a time that is convenient for you. Appointment times are customized according to your needs. When you make your appointment, please keep in mind that we are reserving that time especially for you. We respect your valuable time and we ask the same consideration from our patients. Cancellations less than 48 business hours prior to your appointment could result in a charge according to the length of your missed appointment.

PAYMENT OPTIONS

A. Payment in full at initial visit by check or cash.
B. Payment in full at initial visit by VISA or MasterCard
C. No interest or installment payment arrangements through an outside financial source. Our staff will provide you with information to utilize this fast and simple way for payment of dental treatment.

AUTHORIZATION

I understand that I am responsible for all cost of dental treatment and authorize payment of dental benefits directly to this office. I herby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I have provided to this office on this form and any other completed and signed by me is correct to the best of my knowledge. I will not hold Dr. Mark Birnbaum, D.D.S, Bordentown Dental Arts or any member of the staff responsible for any errors or omissions that I may have made in the completion of my medical or insurance information.

FINANCE CHARGE

If I do not pay the entire new balance of my account within 60 days of the billing date, a Finance Charge of 1.5% will be added to the account for each monthly billing period. In the case of default of payment I promise to pay any legal interest on the balance due, along with any collection costs and reasonable attorney fees incurred to effect collection of this account.

I understand and agree to the above _____ Date _____
(Patient/Parent/Guardian)

Best time to be reached by phone: ( ) Morning ( ) Afternoon ( ) Evening ( ) Email_____

I can best be reached: Home # _____ Work #_____ Cell_____

BORDENTOWN DENTAL ARTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of
(Please Print Name)
Privacy Practices.

Social Security #_____ Email_____

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Dear , Date_____

Please consider this letter as authorization, and request to release, and forward all Dental x-rays within the last 3 to 5 years pertaining to: _____

To the office of Dr. Mark Birnbaum at the address listed below. Thank you for your cooperation.

Sincerely,

Mail to: Bordentown Dental Arts

3 Third Street, Suite 101

Bordentown, NJ 08505

INSURANCE

We will bill your insurance company as a **COURTESY TO YOU.** We will assist in all necessary claims submissions in order to obtain payment for your dental services. You are expected to pay your portion of treatment at the time of service. Your insurance carrier's financial responsibility and your co-payment is only an estimate. Anything not covered by your insurance company will be billed to you and payable upon receipt.

AUTHORIZATION

"I understand that I am responsible for all costs of dental treatment and authorize payment of dental benefits directly to this office. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information contained on this form is correct to the best of my knowledge. I will not hold this dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of these forms numbered # 1 through # 5."

FINANCE CHARGE

"If I do not pay the entire new balance on my account within 60 days of the billing date, a finance charge of 1.5% will be added to the account for each monthly billing period. In the case of default of payment, I promise to pay any legal interest on the balance due, along with any collection costs and reasonable attorney's fees incurred to effect collection of this account."

_____ _____

Patient Signature Date

Bordentown Dental Arts, LLC

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Whom may we thank for referring you to our office? Email: Cell Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No Name of Insurance Carrier?

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact: Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

Patient/Guardian signature *Date*