EMERSON DENTAL
Collective
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Date_____ DL # _____
SSN _____

## Patient Information (Confidential)

Name _____Preferred Name _____M/F ___
Birth date _____ Home Phone _____ Work Phone _____Cell Phone _____
Address _____Apt# _____City/State/Zip _____
Married _____Single _____ Child _____ Other _____ is Patient a Student? Yes ____No _____
E-Mail _____
Patient's or Parent's Employer _____
Employer's Address _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party (If different from patient)

Relationship
Name of Person Responsible for this Account _____ to Patient _____
Address _____ Apt# _____ City/State/Zip _____
Birth date _____ Social Security Number _____ Home Phone _____
Employer _____ Work Phone _____ Cell Phone _____
Is this person currently a patient in our office? Yes _____ No _____

## Insurance Information

Relationship
Name of Insured _____ to Patient _____
Birth date _____ Social Security Number # _____ Home Phone _____
Employer _____Work Phone _____
Insurance Company _____ Group Number _____
Insurance Co. Address _____City/State/Zip _____

**ADDITIONAL DENTAL/MEDICAL INSURANCE** Relationship
Name of Insured _____ to Patient _____
Birth date _____ Social Security Number # _____ Work Phone _____
Employer _____ Insurance Company _____
Group Number _____
Insurance Co. Address _____City/State/Zip _____

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## MEDICAL HISTORY

Primary Physician: Phone number:

Date of last physical:

Please list any prescription medications, over the counter medicines, vitamins, herbs/supplements you are taking:

Are you allergic to or have you had a reaction to:

| | | | | |
|---|---|---|---|---|
| Aspirin | ☐ Y ☐ N | Latex | ☐ Y ☐ N | If yes, please provide information about your experience: |
| Barbiturates, sedatives, sleeping pills | ☐ Y ☐ N | Local Anesthetics | ☐ Y ☐ N | |
| Codeine or other narcotics | ☐ Y ☐ N | Metals | ☐ Y ☐ N | |
| Penicillin or other antibiotics | ☐ Y ☐ N | Hay fever/seasonal allergies | ☐ Y ☐ N | |
| Iodine | ☐ Y ☐ N | Other | ☐ Y ☐ N | |
| Sulfa Drugs | ☐ Y ☐ N | | | |

Have you ever taken a bisphosphonate medication (such as Fosamax, Actonel, Atelvia, Didronel, Bonvia)? ☐ Y ☐ N

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? ☐ Y ☐ N

Are you taking any blood thinners (such as Coumadin, Warfarin, Plavix, Xarelto, Aspirin)? ☐ Y ☐ N

Do you have a history of substance abuse? ☐ Y ☐ N

Are you taking hormonal replacements? ☐ Y ☐ N

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

Have you had a serious illness, operation or been hospitalized in past 5 years? ☐ Y ☐ N
If yes, please explain:

Do you have or been diagnosed with any of the following conditions?

**Heart Health**
- ☐ Y ☐ N Pacemaker/implanted defibrillator
- ☐ Y ☐ N Artificial (prosthetic) heart valve
- ☐ Y ☐ N Previous infective endocarditis
- ☐ Y ☐ N Congenital heart disease (CHD)
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Coronary artery disease
- ☐ Y ☐ N Damaged heart valves
- ☐ Y ☐ N Heart attack
- ☐ Y ☐ N Heart murmur
- ☐ Y ☐ N History of atrial fibrillation
- ☐ Y ☐ N Rhematic heart disease
- ☐ Y ☐ N Stroke

**Respiratory Health**
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Sinus trouble
- ☐ Y ☐ N Tuberculosis

**Skeletal Health**
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Paget's disease
- ☐ Y ☐ N Joint replacement

**Cancer**
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Radiation
- ☐ Y ☐ N Organ or bone marrow/stem cell transplant
- ☐ Y ☐ N Multiple myeloma

**Circulatory Health**
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Blood transfusion
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N High or low blood pressure

**Brain/Mental Health**
- ☐ Y ☐ N Anxiety
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Post traumatic stress disorder
- ☐ Y ☐ N Eating disorder
- ☐ Y ☐ N Other mental health disorder
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Neurological disorder
- ☐ Y ☐ N Headaches
- ☐ Y ☐ N Traumatic brain injury or concussion

**Digestive Health**
- ☐ Y ☐ N GI disease
- ☐ Y ☐ N Acid reflex/heartburn (GERD)
- ☐ Y ☐ N Stomach ulcers

**Immune Health**
- ☐ Y ☐ N AIDS or HIV infection
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Immune deficiency
- ☐ Y ☐ N Frequent infections

**Other**
- ☐ Y ☐ N Chronic pain
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Diabetes (type 1 or 2)
- ☐ Y ☐ N Hepatitis, jaundice or liver disease
- ☐ Y ☐ N Kidney problems
- ☐ Y ☐ N Sexually transmitted infection
- ☐ Y ☐ N Thyroid problems

**Please list any other conditions:**

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 dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date: _____

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## DENTAL HISTORY

Reason for today's visit?

Are you currently experiencing any dental pain or discomfort? ☐ Y ☐ N If yes, where?

Date of last dental visit? What was done at this visit?

Date of last dental x-rays?

Former Dentist: City, State:

Who may we thank for referring you?

Please check yes or no if you have had problems with any of the following:

| | | | | |
|---|---|---|---|---|
| Bad breath | ☐ Y ☐ N | Pain to chew, bite, or swallow | ☐ Y ☐ N | Have you ever had a serious injury to your head or mouth? ☐ Y ☐ N |
| Bleeding gums | ☐ Y ☐ N | Sensitivity hot/cold | ☐ Y ☐ N | If yes, please explain: |
| Blisters/canker sores | ☐ Y ☐ N | Sensitivity to chewing/biting | ☐ Y ☐ N | |
| Growths in the mouth | ☐ Y ☐ N | Sensitivity to sweets | ☐ Y ☐ N | |
| Smoking/tobacco use | ☐ Y ☐ N | Does dental treatment make you nervous? | ☐ Y ☐ N | Have you ever had problems with dental treatment in the past? ☐ Y ☐ N |
| Clicking/popping Jaw | ☐ Y ☐ N | How often do you brush? | | If yes, please explain: |
| Jaw pain on open/close | ☐ Y ☐ N | How often do you floss? | | |
| Pain around ear | ☐ Y ☐ N | Are you happy with your smile? | ☐ Y ☐ N | |
| Grinding/clenching teeth | ☐ Y ☐ N | If not, please list your concerns: | | Have you ever had a reaction to dental anesthesia? ☐ Y ☐ N |
| Dry mouth | ☐ Y ☐ N | | | If yes, please explain: |
| Mouth breathing | ☐ Y ☐ N | | | |
| Snoring | ☐ Y ☐ N | | | |
| Trouble breathing during sleep | ☐ Y ☐ N | | | |
| Loose/broken filings | ☐ Y ☐ N | | | |

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**Financial Agreement:**

Thank you for choosing Emerson Dental Collective as your dental health care provider. We are committed to providing you with the highest quality dental care. Please take the time to familiarize yourself with our financial policies.

As a condition of your treatment by this office, financial arrangements must be made in advance. If you have dental insurance that we accept, we will gladly submit all paperwork needed to collect payment from that insurance. Please keep in mind that most insurance plans do not pay for the entire cost of your dental care. It is the patient's responsibility to know the details of their individual insurance policy.

Dental insurance is an agreement between you and your insurance company, not an agreement or contract between the dental provider and the insurance company. Most insurance company's fee schedules are different from actual fee schedules in a dental office. As a result, there is frequently a remaining balance due after your insurance company provides your benefit. We will estimate, to the best of our ability, this difference and ask for this payment at the time services are rendered.

Any remaining balance after the insurance company has paid your benefit will be your responsibility. If your insurance company fails to release your benefit within 60 days of the treatment rendered, all balances will be due from you or the guarantor responsible for your account. If insurance benefits are paid directly to the policyholder, payment is due in full at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time of service.

**Cancellation Policy:**

If you need to cancel or change your appointment, we require a 48 hour notice. There will be a $50 charge for late cancellations under 48 hours, or no show appointment.

**Co-payments & deductibles are due at the time of service. The total balance, whether dental insurance company pays or not, it is patient's responsibility.**

**By signing below, you have been informed, understand and agreement to these policies.**

Signature: _____

Print Name: _____ Date: _____

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# Informed Consent- General Dentistry

Choosing among dentally reasonable treatment alternatives is a shared responsibility of dentists and patients. In the usual care, a dentist will recommend a course of treatment. While a patient often decides to adopt the recommendation, the ultimate decision is for the patient provided the choice is dentally reasonable. Under the law in New Jersey, a dentist is obligated to inform a patient of dentally acceptable treatment alternatives and their attendant probable risks and outcomes, and the costs relative to the treatment that is recommended and/or rendered, so a patient can make a decision that is informed. This form, together with our conversation about treatment alternatives, risks and outcomes, is intended to fulfill Dentist's obligation to obtain informed consent.

1. Treatment Plan. The Dental Services to be provided include one or more of the following: exam, cleaning, radiographs, fluoride, sealants, whitening, fillings, veneers, crowns, bridges, root canals, simple extractions, surgical extractions, bone grafting, implant placement, implant restoration, dentures, periodontal procedures, and/or orthodontics.
2. Changes in Treatment Plan. During the course of treatment, procedures may need to be added, expanded or changed because conditions are found that were not identified during examination and first were observed during the course of treatment. The most common include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges, or implants. Permission is herby given to perform any additional or expanded dental services that the Dentist determines are necessary. Further, in the Dentist's discretion, I may be referred to a specialist for further treatment, the cost of which is my responsibility.
3. Drugs, Medication, and Sedation. Drugs, medications or anesthesia/sedation can cause allergic and other reactions. Examples include, but are not limited to, swelling, redness, itching, vomiting, diarrhea, numbness or tingling of the lip, gum or tongue (which in rare cases may be permanent) and also in rare cases, anaphylactic shock. Since they also may cause drowsiness and impair coordination or awareness, a motor vehicle or hazardous device should not be operated before full recovery is achieved. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days, as well as those that have been prescribed within the last 6 months but not taken, and all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by Dentist may result in continued or aggravated infection and pain and potential resistance to effective treatment. In addition, antibiotics can reduce the effectiveness of birth control pills.
4. Fillings. The most common conditions encountered with filings are pain, sensitivity to temperature or pressure, nerve damage, damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems and occasional allergic reactions to filling materials.
5. Endodontic Treatment (Root Canal). Although root canal treatment to retain a tooth that otherwise might need to be extracted is very common dental procedure with a reported success rate over 90%, there are some risks and complications. The most common include swelling, soreness, infection, bleeding, trismus (restricted jaw opening), numbness or tingling of the lips, gum or tongue (which in rare cases may be permanent), discoloration of adjacent teeth or soft tissue, perforation of the root, and fractures (splits) of the crown or root of the tooth or restoration. Occasionally, one of the delicate instruments used to perform a root canal may separate in the tooth. A failed root canal may require re-treatment, surgery, or extraction. Once a tooth has received root canal treatment, it tends to be more brittle and weak. To minimize the likelihood of a fracture, restoration with a crown is recommended. There is no guarantee that root canal treatment will save a tooth.

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6. Crowns, Onlays/Inlays, Bridges, Veneers, Bonding. Sometimes, it is difficult or impossible to exactly match the color of artificial teeth or restorative materials with natural teeth. Although assistance will be provided by the dentist, it is my responsibility to make changes, if any, (including, for example, shape, size, fit, and color) before permanent cementation. After a temporary crown has been placed, it is essential to have the new crown cemented as soon as it is ready because the temporary crown is not intended to function as a permanent restoration. Failing to replace the temporary crown could lead to decay, gum disease, infections, problems with the bite and even loss of tooth. Further, if there if prolonged delay in placing thee permanent crown, it may no longer properly fit.
7. Periodontal (Gum) Health. Periodontal disease is a serious condition that causes gum inflammation and bone loss that can lead to tooth loss. Keeping this in mind, alternative treatment plans have been explained, including a consult with a periodontist, gum surgery, extractions, implants, and/or other removable or fixed prosthesis. Undertaking any dental procedures may have a future adverse effect on overall periodontal health, and also periodontal disease can reoccur after treatment. It is imperative to maintain proper homecare and regular check-up/maintenance visits at all times.
8. Extractions. Alternatives to extractions (tooth removal) have been explained, including root canal therapy, crowns, periodontal surgery, etc. Removing teeth does not always remove all of the infection if present, and it may be necessary to have further treatment. The risks involved include pain, swelling, spread of infection, dry socket, loss of feeling in other teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time, or fractured jaw. If complications arise during or following treatment, further treatment by a specialist may be required, the cost of which is my responsibility.
9. .Dentures. Sore spots, altered speech, and difficulty eating are common problems when adjusting to wearing dentures. Immediate dentures may be uncomfortable and may require considerable adjustments and several relines. A permanent reline will be needed at a later date, which is not included in the denture fee. It is my responsibility to return for delivery of dentures. The failure to keep delivery appointment may result in poorly fitted dentures. If a remake is required due to these delays of over 30 days, additional fees may apply.

I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in treatment plan, as detailed above.

Patient Signature _____ Date_____


**HIPAA Patient Consent Form**

I understand that I have certain rights to privacy regarding my protected health information. The rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other health care providers involved in my treatment);
2. Obtaining payment from third party payers (e.g. my insurance company);
3. The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature _____ Date_____

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# Notice of Privacy Practices for the office of Emerson Dental Collective

**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.**

**Uses and disclosures to carry out treatment, payment, and health care operations**

**Treatment -** This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

**Payment -** This practice may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

**Health care Operation -** This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

This practice may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information

**Authorized Uses or Disclosures -**The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.
For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

**Uses or disclosures requiring an opportunity for the individual to agree or object -** For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

**Uses and disclosures for which an authorization or opportunity to agree or object is not required -** The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

**Uses and disclosures required by law -** This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

**Uses and disclosures for public health activities -**This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

**Disclosures about victims of abuse, neglect or domestic violence** This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

**Uses and disclosures for health oversight activities -**This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

**Disclosures for judicial and administrative proceedings -**

This practice may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

**Disclosures for law enforcement purposes** - This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

**Uses and disclosures about decedents -** This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

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**Uses and disclosures for cadaveric organ, eye or tissue donation purposes** - This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

**Uses and disclosures for research purposes -** This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

**Uses and disclosures to avert a serious threat to health or safety** - This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Uses and disclosures for specialized government -** This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

**Disclosures for workers' compensation -** This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

**Patient rights under HIPAA -** The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section**.**

**Right of an individual to request a restriction of uses and disclosures -** This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

**Confidential communication requirements -** This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

**Access of individuals to protected health information -** An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the beginning of this document.

**Amendment of protected health information -** An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

**Accounting of disclosures of protected health information -** An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

**Right of Breach Notification -** An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

**Copy of this notice -** You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

**Our Duties -** This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our offices(s) and posted on our web site, if applicable.

**Complaints -** If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer. This practice will not retaliate against any individual for filing a complaint.

**Contact -** You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice

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