Hillsborough Dental Center

frontdesk@hillsboroughdental.com
107 Omni Drive Hillsborough, NJ 08844 908-359-1112

Welcome to our Practice!

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Gender: ○Male ○Female **Family Status**: ○Married ○Single ○Child ○Other

Birth Date:____________ **Social Security#:**____________ **EmailAddress:**____________

Home Phone#:____________ **Cell#:**____________ **Work#:**____________

Home Address:____

In the event of an emergency, who should be notified? Please list Name and Phone number below:

____

____

How did you hear about us? ○Google ○ Facebook ○Yelp ○Doctor ○Patient ○Other

If a patient or doctor please list name:____

Primary Dental Insurance Information:

The following is for: ○the patient ○the person responsible for payment ○both ○not applicable

Patient Employer Name:____________________ **Phone#:**____________

Patient Employer Address:____

Name of Insured: ____________ ____________ ____ **Insured DOB:**________
Last First MI

Patient Relationship to insured: ○Self ○Child ○Other

Insurance Carrier:____________ **ID#:**____________ **Group#:**____________

Insurance Plan Name:____________ **Insurance Address:**____________

Subscriber Name:____________ **Subscriber DOB:**________ **Subscriber Phone#:**________

Subscriber Address:____

Subscriber Employer:____________ **Subscriber Address:**____________

____

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Secondary Dental Insurance Information:

Name of Insured: ________________ ____________________ _____ **Insured DOB**:________
Last First MI

Patient Relationship to insured: ○Self ○Child ○Other

Insurance Carrier:______________________**ID#**:___________________ **Group#**:____________

Insurance Plan Name:__________________**Insurance Address**:_________________________

Subscriber Name:________________**Subscriber DOB**:_________ **Subscriber Phone#**:________

Subscriber Address:____

Subscriber Employer:__________________**Subscriber Address**:_________________________

Insurance Authorization:

□ By checking this box, I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of electronic 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.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

○Pre-Med Amox	○Rheumatic fever	○Latex	○Flagyl	○Biaxin
○Afib	○ShellFish	○Lupus	○Grave's Disease	○Ceclor
○Anesthetics	○Stomach Issues	○Migraines	○Head Injuries	○ Codeine
○Aspirin	○Tetracycline	○Neurentin	○Heart Stent	○Dust. Mold, Mildew
○Blood Disease	○Trigeminal neuralgia	○Peanuts	○Hoshimoto's	○Erythro
○Cefeil	○Ulcers	○Procadia	○Jaundice	○GERD
○COPD	○Pre-Med Clind	○Rheumatism	○Levaquin	○Growths
○DVT	○All Statins	○Shrimp	○Lyme Disease	○Tumors

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○Excessive Bleeding	○Anxiety	○Stroke	○Mitral Valve Prolapse	○Hearing Loss
○Glaucoma	○Asthma	○Thyroid	○Penicillin	○Hepatitis
○Hay Fever	○Breastfeeding	○Tuberculosis	○Radiation Treatment	○Hypothyroid
○Heart Disease	○Chronic Pain	○VasoVagal	○Seasonal	○Keflex
○High BP	○Diabetes	○Pre-Med other	○Sinus Problems	○Liver Disease
○IBS	○Epilepsy	○Allergies	○Sulfa	○Medical Alert
○Kidney Disease	○Fainting	○Arthritis	○Topical Steroids	○N20
○Low BP	○Gout	○Augmentin	○Tumors	○Pacemaker
○Mental Disorder	○Hay Fever	○Cancer	○Venereal Disease	○Percocet
○Nervous Disorder.	○Heart Murmur	○Clindamycin	○Adrenal Fatigue	○Respiratory Problems
○Parkinson's	○HIV	○Dizziness	○Anemia	○Ulcerative Colitis
○Pregnancy	○Iodine	○Epinephrine	○Artificial Joints	○Other

○Ever Been Hospitalized (illness or injury)	○Presently being treated for any other illness
○Taking medication for weight control (IE: fen-phen)	○Taking dietary supplements
○Subject to frequent headaches	○A smoker or smoked previously
○FEMALE: Taking birth control pills	○FEMALE: Pregnant

If any condition or alert selected above needs further clarification, please explain below:

____

____

Do you take antibiotic premedication for your dental visits? ○YES ○NO

If YES, please explain on the lines provided below:

____

____

Please list known allergies on the lines provided below:

____

____

____

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Medical History Continued

Please list any medications you are currently taking:

____
____
____
____

Describe any current medical treatment, impending surgery, or other treatment that my affect your dental treatment:____
____

Name of family physician and telephone#:____

Most recent physical exam and purpose:____
____

Pharmacy Name and location:

____
____

☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

____

Dental History

How would you rate the condition of your mouth: ○ Excellent ○ Good ○ Fair ○ Poor

Previous dentist name and how long have you been a patient there:

____
____

Date of most recent exam:____________________ **Date of most recent dental x-rays:**____________________

I routinely see my dentist every: ○ 3mo ○ 4mo ○ 6mo ○ 12mo ○ Not routinely

What is your immediate concern?

____
____

Are you fearful of dental treatment? ○ YES ○ NO If so, how fearful, on a scale of 1 (least) to 10 (most) ______

Person history, check all that apply:

- ○ Had an unfavorable dental experience
- ○ Complications from dental treatment
- ○ Trouble getting numb
- ○ Had any reactions to local anesthetic
- ○ Had/Have braces, orthodontic treatment
- ○ Teeth removed
- ○ Bite adjusted

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Smile Characteristics, check all that apply:

O Would like to change the appearance of your teeth.
O Experience with whitening (bleaching) your teeth.
O Feel/felt uncomfortable or self conscious about the appearance of your teeth.
O Been disappointed with the appearance of previous dental work.

Bite and Jaw Joint, check all that apply:

O Problems with your jaw joint.
O Problems chewing.
OTeeth have changed in the last 5 years, become shorter, thinner, or worn.
O Chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits.
O Clench your teeth in the daytime or make them sore.
O Problems with sleep or wake up with an awareness of your teeth.
O Wear or have worn a bite appliance

Tooth structure, check all that apply:

O Amount of saliva in your mouth seems too little or difficulty swallowing any food
O Cavities within the past 3 years
ONotice or have holes on the biting surface of your teeth
O Sensitivity to hot, cold, biting, sweets, or have avoided brushing any part of your mouth
O Teeth with grooves, notches, chips, a cracked filling or pain
O Food gets caught between any teeth

Gum and Bone, check all that apply:

O Gums bleed when brushing or flossing
O Treated for gum disease or were told you have lost bone around your teeth
O Noticed an unpleasant taste or odor in your mouth
O History of periodontal disease in your family
O Experienced a burning sensation in your mouth.

If any of the checked boxes need further explanation, please describe:

___

___

___

___

Epworth Sleepiness Scale

The Epworth sleepiness scale is widely used in the field of sleep medicine asa subjective measure of a patient's sleepiness.

For each situation, decide whether or not you have or had the following in regards to dozing off:

0= No chance 1= Slight chance 2= Moderate chance 3= High Chance

Sitting and Reading: _______	Watching TV: ________
Sitting in a public area (theater or meeting): _______	As a passenger in a car for an hour without break: ____

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Lying down to rest in the afternoon: _______	Sitting and talking to someone: _______
Sitting quietly after a lunch without alcohol: _______	In a car, while stopped for a few minutes in traffic: ____

Total Score (0-24): ____________

Bang Questionnaire

1. Do you SNORE loudly? ○ **YES** ○ **NO**
2. Do you often feel TIRED, fatigued or sleepy during the daytime? ○ **YES** ○ **NO**
3. Has anyone OBSERVED you stop breathing during your sleep? ○ **YES** ○ **NO**
4. Do you have or are you being treated for HIGH BLOOD PRESSURE? ○ **YES** ○ **NO**
5. Do you have a BMI more than 35? ○ **YES** ○ **NO**
6. Age over 50 years old? ○ **YES** ○ **NO**
7. Neck Circumference greater than 16 inches? ○ **YES** ○ **NO**
8. Gender: Male? ○ **YES** ○ **NO**

High Risk of OSA: YES 5-8
Moderate Risk of OSA: YES 3-4
Low Risk of OSA: YES 0-2

I attest that all the information disclosed above to my knowledge is up to date and relevant. I understand that failure to disclose accurate health information can result in inadequate treatment from Shore Premier Dental Arts due to insufficient information. I agree to notify Shore Premier Dental Arts if new changes to my demographic information as well as health history apply.

Patient Name:_________________________**Patient Signature:**____________________________**Date:**______

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Financial and Scheduling Policies

Thank you for allowing Hillsborough Dental Center the opportunity to care for your lifetime dental needs. We are excited to partner with you to improve and maintain your oral health. We will be sensitive to your financial and scheduling circumstances and do everything possible to help you achieve optimal oral health. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. We ask that there is a clear understanding as outlined below of our financial and scheduling policies. Thank you!

Financial Guidelines:

- Payment is due at the time services are rendered. This would include estimated deductible, co-pays, and co-insurances.
- For your convenience, treatment costs can be paid for with cash, credit card, check, or third party financing.
- Returned checks are subject to a $45.00 fee to cover processing fees incurred by our office.
- Account balances over 60 days are subject to a $35.00 late fee and referral to collections agencies which may also lead to additional charges, fees, and credit implications. In the event an account becomes delinquent, the remaining balance plus the sum of any collection agency fees. In this event, I authorize the release of financially identifiable information concerning my account.
- All emergency dental services and any dental service performed without previous financial arrangements must be paid in full at the time services are rendered.

Patients with Insurance:

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. We will bill your insurance directly to collect reimbursement for your treatment so that you will receive the full benefits of your insurance coverage. At HDC, we strive to maximize your insurance benefits and help to make any remaining balance easily affordable. Please be advised that any amounts estimated to be paid by insurance providers ***are estimates only***, and that no guarantee can be made by our office regarding these amounts. We will do all we can to ensure your estimate is as accurate as possible. However, insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums/limits which are your responsibility.

Regarding maximums, if you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period as it is possible that some treatment may have been completed outside of HDC. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan. In the event that the amount paid by your insurance(s) differs from the estimate, you will be billed for the outstanding balance.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our practice is

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Committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Insurance payments are ordinarily received 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected, ***at this time the remaining balance will be due and payable by you and you will be responsible for collection of your benefits directly from your insurance carrier.*** If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for and with regards to optimal oral health for our patients. It is our goal to provide our patients with the level of care that they desire and deserve, and we will not allow insurance plans to dictate the level of care we offer to our patients. We maintain that insurance is a method of payment, and not a method of treatment. Hillsborough Dental Center does not render services on the assumption that our charges will be paid in full by an insurance company.

Deposit Policy: Certain appointments will require a deposit to reserve appointment time. Appointment times greater than 90 minutes, specialty services, or certain high demand appointment times may require a deposit of 50% of the future copay to reserve the appointment time. Remaining balances can be paid at the time treatment is rendered.

Minors: Minors must be accompanied by the parent or legal guardian. The parent or legal guardian accompanying a menor, who has consented to treatment are responsible for full payment at time of service. Treatment may be denied if signed treatment plans and financial arrangements are not made by the legal guardian.

Missed Appointment (s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to prevent scheduling problems for our patients, we require at least 48 hour notice for cancellations or for rescheduling your appointments. We understand that unforeseen circumstances may arise, which may result in changing or missing your appointment. A charge of $100.00 per hour may be assessed for multiple missed, short notice or cancelled appointments.

Multiple failed appointments may result in being flagged as "Same Day Only" where appointments are given on the same-day basis only. Further, frequent offenders may be dismissed from our dental practice.

Please help us care for you better by keeping scheduled appointments.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communication with you: By signing below, you are authorizing us to call/text/email you at any numbers/address you provide. I authorize the dentist or her designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or in paper form to my insurance carrier, another oral health provider/specialist or any other related entities that require such information to be submitted.

Name (please print):______________________________

Signature:________________________________ Date:________________

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Notice of Privacy Practices Acknowledgement and Consent

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

Your comments regarding acknowledgement and consent:

____

____

____

I authorize the following individuals (example: spouse, parent/guardian, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:

Name:________________________________
Relationship to patient:________________________

Name:________________________________
Relationship to patient:________________________

Name:________________________________
Relationship to patient:________________________

If you do not list anyone, we **WILL NOT** share information regarding your account.

I authorize contact from this office to confirm my appointments, treatments and billing information via:

○ Cell Phone Confirmation	○ Text Message to my cell phone
○ Home Phone Confirmation	○ Email Confirmation
○ Work Phone Confirmation	○ Any of the above

I authorize information about my health be conveyed via:

○ Cell Phone Confirmation	○ Text message to my cell phone

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○Home Phone Confirmation	○Email Confirmation
○Work Phone Confirmation	○Any of the above

I approve being contacted about special services, events, fundraising efforts or new health information on behalf of this office via:

○Phone Message	○Text and Email Messages
○Any of the above	○None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

Patient Name:____________________ Patient signature:__________________ Date:_____

If not patient:

Name:__________________________ Signature:______________________ Date:______

Relationship to patient:_________________________________

FOR OFFICE USE ONLY:

As a privacy officer, I attempted to obtain patient's (or representative's) written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____

____

____

Name of privacy officer:____