

### Patient Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       |   |
|  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female

Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

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

Street

Apartment #

City

State

Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Street

City,

State

Zip Code

Phone

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last

First

MI

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

Insured's Address: \_\_\_\_\_

Street

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

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

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last

First

MI

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

Insured's Address: \_\_\_\_\_

Street

City

State

Zip Code

Insured's Employer Name: \_\_\_\_\_

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

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian

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

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party

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

Relationship to Patient: \_\_\_\_\_

# Elite Dental Associates

Dr. Joseph A. Terranova  
1 Bethany Road  
Bldg 4 Suite 54  
Hazlet, NJ 07730  
(732)264-6202

## Signature on file/Release of Information

By signing below I authorize Elite Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents. I hereby authorize payment of benefits otherwise payable to me, directly to Elite Dental. I authorize release of any information including xrays relating to the claim. A photocopy of this document may act as an original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian if under 18

I understand that I am responsible for any deductibles, co-payments and/or non-covered services. These payments are due at the time services are rendered. Should my insurance plan cover less than originally estimated or release no payment at all I will be billed for the balance. All balances must be paid in full within 30 days of receipt of bill.

I understand the amount of dental benefits I receive is determined by my insurance plan and not by the dental office. I understand some dental services may not be covered by my plan, and that I am responsible for those services directly. I understand that the dental office will attempt to *estimate* my financial responsibility. This estimate is in no way a guarantee of payment. My insurance may pay less or more than estimated. In addition my insurance may not pay at all.

Most insurance companies reimburse our office in a timely fashion, however, should your insurance company not remit payment to our office within 60 days of their receipt of claim you will be responsible for the entire balance.

By signing I acknowledge that I have read, understand and accept the above financial responsibility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian if under 18

## HIPAA STATEMENT

Acknowledgement of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations

By signing below, I hereby acknowledge that I have been provided with a copy of the offices Notice of Privacy practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian if under 18