Main Street DENTAL ARTS
Family And Cosmetic Dentistry

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Last name	First name	Middle initial
Preferred Name	Date	
Address		
City	State	Zip
Date of Birth	SS#	
Home Phone	Work Phone	
Cell Phone	E-mail	
How would you prefer to be contacted? ❑Cell ❑Home ❑ Work ❑E-Mail		
❑Married ❑ Single ❑Widowed ❑Divorced ❑ Separated ❑Minor Gender ❑ M ❑ F		
Occupation	Employer/School	Employer Phone
Whom may we thank for referring you?		
In the event of emergency, who should be notified?	Phone	

DENTAL INSURANCE

Name of insured			
Relationship to patient: ❑Self ❑Spouse ❑Child ❑Other_____	Is insured a patient? ❑Yes ❑No		
Insured's SS#	Employer	Business Phone	Date of Birth
Employer Address		Insurance Company	
Insurance Address		Group #	Subscriber #
	Is patient covered by additional insurance? ❑Yes ❑No		
Name of insured			
Relationship to patient: ❑Self ❑Spouse ❑Child ❑Other_____	Is insured a patient? ❑Yes ❑No		
Insured's SS#	Employer	Business Phone	Date of Birth
Employer Address		Insurance Company	
Insurance Address		Group #	Subscriber #

DENTAL HISTORY

PATIENT'S NAME:	Reason for today's visit
Previous Dentist	Reason for changing dentists
Date of last dental visit	Date of last dental X-rays/cleaning
How often do you brush?	How often do you floss?
Is there anything that you would like to improve about your smile?	

Place a mark next to "yes" or "no" to indicate if you have had any of the following

❑Yes ❑No	Bad breath	❑Yes ❑No	Facial or jaw injury	❑Yes ❑No	Mouth pain
❑Yes ❑No	Bleeding gums	❑Yes ❑No	Fingernail or foreign object biting	❑Yes ❑No	Orthodontic treatment
❑Yes ❑No	Gums swollen or tender	❑Yes ❑No	Cigarette, pipe, or cigar smoking	❑Yes ❑No	Pain around ear
❑Yes ❑No	Chew on one side of mouth	❑Yes ❑No	Grinding or clenching teeth	❑Yes ❑No	Periodontal treatment
❑Yes ❑No	Clicking or popping jaw	❑Yes ❑No	Blisters on lips or mouth	❑Yes ❑No	Sensitivity to cold
❑Yes ❑No	Pain in jaw	❑Yes ❑No	Loose teeth	❑Yes ❑No	Sensitivity to heat
❑Yes ❑No	Dry mouth	❑Yes ❑No	Broken fillings	❑Yes ❑No	Sensitivity to sweets
❑Yes ❑No	Sores or growths in mouth	❑Yes ❑No	Chewing tobacco	❑Yes ❑No	Sensitivity when biting

HEALTH HISTORY

Physician's name	Phone	Pharmacy	Phone

Have you ever been told that you need to take an antibiotic prior to dental treatment? ❑Yes ❑No For what condition?

Place a mark on "yes" or "no" to indicate if you have or had any of the following

❑Yes ❑No	AIDS/HIV	❑Yes ❑No	Circulatory Problems	❑Yes ❑No	Heart Murmur
❑Yes ❑No	Anemia	❑Yes ❑No	Congenital Heart Lesions	❑Yes ❑No	Heart Problems
❑Yes ❑No	Arthritis, Rheumatism	❑Yes ❑No	Cortisone/Steroid Treatments	❑Yes ❑No	Hepatitis Type ____
❑Yes ❑No	Artificial Heart Valves	❑Yes ❑No	Cough, persistent or bloody	❑Yes ❑No	Herpes
❑Yes ❑No	Artificial Joints	❑Yes ❑No	Diabetes	❑Yes ❑No	High Blood Pressure
❑Yes ❑No	Asthma	❑Yes ❑No	Emphysema	❑Yes ❑No	Kidney Disease
❑Yes ❑No	Bleeding abnormally	❑Yes ❑No	Epilepsy/Seizures	❑Yes ❑No	Liver Disease
❑Yes ❑No	Blood Disease	❑Yes ❑No	Fainting/Dizziness	❑Yes ❑No	Jaundice
❑Yes ❑No	Cancer/Chemotherapy	❑Yes ❑No	Glaucoma	❑Yes ❑No	Low Blood Pressure
❑Yes ❑No	Chemical dependency/Drug use	❑Yes ❑No	Headaches	❑Yes ❑No	Pacemaker
❑Yes ❑No	Nervous Problems	❑Yes ❑No	Mitral Valve Prolapse	❑Yes ❑No	Stomach Problems
❑Yes ❑No	Psychiatric Care	❑Yes ❑No	Radiation Treatment	❑Yes ❑No	Respiratory Disease
❑Yes ❑No	Taken Fen-Phen or Redux	❑Yes ❑No	Rheumatic Fever	❑Yes ❑No	Shortness of Breath
❑Yes ❑No	Sinus Trouble	❑Yes ❑No	Skin Condition	❑Yes ❑No	Stroke
❑Yes ❑No	Swollen Feet or Ankles	❑Yes ❑No	Thyroid Problems	❑Yes ❑No	Tuberculosis
❑Yes ❑No	Ulcers	❑Yes ❑No	Venereal Disease	❑Yes ❑No	Wear contact lenses
❑Yes ❑No	Infective Endocarditis	❑Yes ❑No	Organ Transplant	❑Yes ❑No	Surgery/Operation

Women: Are you pregnant? ❑Yes ❑No Due Date _____ Are you nursing? ❑Yes ❑No Taking Birth Control? ❑Yes ❑No

Do you have any other health conditions that we should know about?

Have you been hospitalized or admitted to the hospital for emergency treatment during the past 2 years?

Please list all medications you are currently taking, including over the counter medications (use an additional paper if necessary)

Medicine_____ Condition_____ Medicine _____Condition _____

Medicine_____ Condition_____ Medicine _____Condition _____

Allergies: ❑ Aspirin ❑Ibuprofen ❑ Codeine ❑ Local Anesthetic ❑Latex ❑ Penicillin ❑ Sulfa ❑ Sulfites ❑ Other _____

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 my next appointment without fail.

Signature of Patient, Parent or Guardian_____Date_____Relation _____

Print Patient Name _____ Print Name of Signer if other than Patient _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

SECTION A: PATIENT/GUARDIAN GIVING CONSENT *(PLEASE COMPLETE THE HGHLIGHTED SECTIONS)*

Patients Name: _____

Patients D.O.B. : _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. **YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY. A COPY CAN ALSO BE PRINTED FROM OUR WEBSITE,** www.mainstreetdentalartsnj.com or http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Main Street Dental Arts, 291 Main Street, Chatham, NJ 07928 (973) 635-9091

A. Consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I, _____ *(Individual completing form)*, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

(Patient or Guardian if patient is a minor)

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

B. Acknowledgement of Notice of Privacy Practices

I, _____, have received acknowledgement of this office's Notice of Privacy Practices.

_____ _____

Signature *(Patient or Guardian if patient is a minor)* Date

C. Instructions for Revocation of Consent

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

D. Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

(Patient or Guardian if patient is a minor)

You May Refuse to Sign This Acknowledgement*

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INFORMED CONSENT – GENERAL DENTISTRY

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 an informed decision. Most procedures are discussed below, not all of which may pertain to your needs right now, since the Dentist may recommend further treatments at future examinations. This form, together with our conversation about treatment alternatives, risks and outcomes, is intended to fulfill Dentist's legal obligation to obtain informed consent. Please read all the items below and sign the bottom of the form.

1. **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 first identified during examination and were observed during the course of treatment. The most common include the need for root canal therapy and more extensive restorative procedures, such as crowns, bridges, or implants. Further, in the Dentist's discretion, I may be referred to a specialist for further treatment, the cost of which is my responsibility.
2. **Drugs, Medications, and Sedation.** Drugs, medications, or anesthesia/sedation can cause allergic and other reactions such as: 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. For women, antibiotics can reduce the effectiveness of birth control pills.
3. **Fillings.** The most common conditions encountered with fillings are pain, sensitivity to temperature or pressure, fractures of teeth or roots, nerve damage, damage to other teeth, occlusal (bite) discrepancies, temporomandibular joint problems and occasional allergic reactions to filling materials.
4. **Endodontic Treatment (Root Canal Therapy).** I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. Occasionally, one of the delicate instruments used to perform root canal therapy may break 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 restoration with a crown is recommended.
5. **Crowns, Onlays/Inlays, Bridges, Veneers and 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 the new crown cemented as soon as it is ready. Other possible conditions are similar to those listed under "fillings."
6. **Dentures.** I realize that dentures are artificial. The problems of wearing these appliances will be explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture will be the "teeth in wax" try-in visit. Immediate dentures are considered transitional, a new set of dentures and/or relining of the denture may be required after healing and shrinkage is complete, at an additional charge.
7. **Extractions.** Alternatives to removal, as well as replacement options, have been explained. Possible complications include bleeding, swelling, bruising, pain, infection, dry socket, damage to the adjacent teeth or restorations, opening to the sinus, incomplete removal of tooth fragments, fracture of the bone or bone splinters, and temporary or permanent numbness.

CONSENT: I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform the diagnostic and treatment procedures deemed necessary. I understand that dentistry is not an exact science, therefore reputable practitioners cannot guarantee results. In addition, all the procedures have inherent risks associated with them. I understand that another dentist may treat me in this office, and that he/she is individually responsible for the dental care rendered to me. If I ever have any change in my health or change in my medication, I will inform the Doctor or Hygienist at the next appointment. I have discussed/will discuss treatment alternatives, risks, outcomes and costs with the Dentist and have had/will have all of my questions answered before making a decision.

Signature (Patient, Parent or Guardian) _____

Print name (Patient) _____ Date _____

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Patient Photo Release Form

I _____, hereby authorize **Rebecca Jackson, DDS** or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other healthcare professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information would not be used (including full face photos, name, etc). I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Print Name: _____

Signature:_____

Date:_____

Late Payment Policy

Statements are sent at the end of each month. Payment is due in full at the time of your appointment, unless a payment schedule has been pre-arranged with the office of Rebecca Jackson, DDS LLC.
Accounts not paid in FULL will incur a monthly finance charge of 1.5% of the unpaid balance.
Accounts past due in excess of 3 months will be sent to our collections attorney.

I have read and agree to the Late Payment Policy and understand that delinquent accounts will be assigned to our collections attorney.

Signature: _____ Date: _____

Print Name: _____

Cancellation Policy

As a courtesy to all patients, we ask that a 48 hour notice be given for a cancelled appointment.
If we have not received sufficient notice, a charge may be applied to your account.

I understand and agree to our cancellation policy.

Signature: _____ Date: _____

Print Name: _____