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5429 Harding Highway,
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 Mays Landing NJ, 08330
 Tel (609) 625-0505
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Patient Health Records

Patient's Name _____ Date _____
 Male Female Single Married Divorced Widowed Child
 Date of Birth _____ Social Security _____
 Address _____ Cell Phone () _____
 City _____ State _____ Zip _____ Work Phone () _____ EXT: _____
 Home Phone () _____ Referred by _____
 E-mail _____ Occupation _____
 Please DO NOT e-mail me Please DO NOT send me text messages

YOUR DENTAL AND MEDICAL HISTORY IS IMPORTANT. MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT PERMISSION.

I understand that the information that I give today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any dental service I may need during diagnosis and treatment.

 Signature of patient, parent or guardian Date _____ Relationship to Patient _____

Medical Health

General Health Excellent Good Fair Poor

Name and address of Physician _____

Are you taking any prescription/over-the-counter medications? Yes No If yes, please list: _____

Have you been treated for: (please check all boxes that apply)

Abnormal Blood PressureHigh <input type="checkbox"/> Low <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis.....Type_____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia..... Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV/AIDS Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joints or Implants..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valve Yes <input type="checkbox"/> No <input type="checkbox"/>	Medication Allergy..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental Disorders Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer..... Yes <input type="checkbox"/> No <input type="checkbox"/>	MRSA (Staph infection) Yes <input type="checkbox"/> No <input type="checkbox"/>
Cold Sores..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Disorders..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Congestive Heart Disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Therapy Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Lesions..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug Addiction..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Smoker..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Problems Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Head Injuries..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Surgical Shunts, Plates, or Pins..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Attack Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Murmur Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis or Lung Disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Pacemaker Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Surgery Yes <input type="checkbox"/> No <input type="checkbox"/>	Women:
Hemophilia..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Due Date: _____
Blood Disorders..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you nursing? Yes <input type="checkbox"/> No <input type="checkbox"/>
.....If yes, which: _____	Other _____

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Are you currently taking or have you ever taken bisphosphonates, either orally or by I.V.?..... Yes No
(Examples: Aredia, Zometa, Fosamax, Actonel, Boniva)

Are you allergic to any of the following? Penicillin Aspirin Erythromycin Latex Other
 Dental Anesthesia Codeine Tetracycline Sulfate

Please list any other drugs that you are allergic to: _____

Other physical conditions we should be aware of: _____

Are you subject to prolonged bleeding? Yes No

Are you subject to fainting spells? Yes No

Dental History

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Are you having discomfort at this time? Yes No

Have you had any injuries to your mouth, teeth or head? Yes No if yes, explain _____

Are your teeth sensitive to hot, cold, or sweet? Yes No

Do you have bleeding gums? Yes No

When was your last dental appointment? _____

Have you ever had gum treatments? _____ if yes, when _____

How often do you floss your teeth? _____

How often and when do you brush your teeth? _____

Have you had any unpleasant dental experience in the past? _____

In order to properly diagnose and treat dental problems we require, and it is recommended by the American Dental Association that x-rays be taken. A full series of x-rays and/or a panorax x-ray may be covered by your dental insurance every 3-5 years and bite-wing x-rays every 6 months to a year. If insurance does not cover or no insurance is available it will then be the patient's responsibility to pay for x-rays. No x-rays will be taken without patient/guardian's consent and financial obligations explained.

- I agree to this treatment
- I hereby waive the need for this treatment and fully understand the risks involved with not having a dental x-ray.

Signature of patient, parent or guardian

Date

Relationship to Patient

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Dental Insurance Information

Primary Dental Insurance

Person Responsible for this Account _____
Dental Insurance Company _____
Subscriber Employer _____
Subscriber Name _____
Subscriber Social Security # _____
Subscribers ID # _____
Subscribers Date of Birth _____
Name of Spouse/Guardian _____
Group Number _____

Secondary Dental Insurance

Person Responsible for this Account _____
Dental Insurance Company _____
Subscriber Employer _____
Subscriber Name _____
Subscriber Social Security # _____
Subscribers ID # _____
Subscribers Date of Birth _____
Name of Spouse/Guardian _____
Group Number _____

IMPORTANT DENTAL INSURANCE, PAYMENT AND FINANCING INFORMATION

Our fees are based on providing the finest care, skill and time required for the appropriate treatment. We believe open communication is important and will discuss your care and associated fees in detail with you before beginning any treatment.

Insurance Information

Understanding your insurance benefits can be very challenging, and each plan differs in its covered services, deductibles, co payments, and policy exclusions. Our experienced front desk team can help to make your plan's terms clear. It is important for you to become familiar with your insurance plan. At all times, you can be confident that we will always provide you with our best services without regard to the limitations imposed by your insurance coverage. As a courtesy to our valued patients Brickworks Dental will file your insurance claim electronically on the day of your visit, and request payment of your benefit directly to our office. Brickworks Dental will research your dental insurance plan prior to your visit, and advise you of benefits available to you. Brickworks Dental will coordinate benefits when you have more than one dental insurance plan. Brickworks Dental will attach all supporting documentation to your claim, such as narratives and appropriate radiographs. Brickworks Dental will preauthorize large treatment plans to determine exact benefits. Brickworks Dental will follow the American Dental Association guidelines for coding and filing insurance claims.

As the insurance policy holder, you must: Understand that although we may participate with your insurance plan, you own the policy and we have no leverage to obtain payments or benefits from your insurance carrier. You are responsible for all fees associated with your treatment regardless of your insurance coverage. Insured must realize that dental insurance policies may restrict payment for some services, may use restricted fee schedules, or may exclude some procedures based on prior conditions or waiting periods. **Insured must pay all fees not covered by insurance and all estimated co-pays at the time of service.** Insured must pay any fees the insurance company does not pay our office within 75 days. **Please keep our office informed of any changes to your insurance coverage or employment.**

_____ Date _____ Relationship to Patient _____
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Financial Policy and Consent

Financial Policy

To maintain efficient practice operations, and to prevent any misunderstandings, we ask that you review and adhere to the following financial arrangements. **Payment for dental services provided is due at the time service is rendered unless other arrangements have been made in advance. For our patients with dental insurance, this means that your deductible and co-pay is due at this time.** We will work with you to maximize your insurance benefits; however, you are fully responsible for all fees associated with your treatment regardless of your insurance coverage. For your convenience, we accept cash, checks, debit, Visa, MasterCard, Discover, American Express, CareCredit, and Chase Health Advance. There is a \$25 check fee for checks that are not honored by your bank. This fee will be applied to the patient's account along with the unpaid balance for services. When a balance is due on your account, you will receive a monthly statement. We reserve the right to charge a late fee of \$25 each month to any account with an outstanding balance more than 30 days past due. If collection services are required due to non-payment, all collections and attorney fees will be applied to your outstanding balance. Please contact our office if your statement does not reflect your insurance company's payment within four to six weeks following your treatment. Any remaining balance after your insurance company has paid is your responsibility, and prompt remittance is appreciated.

I hereby authorize Brickworks Dental to release my records to my insurance company. I hereby authorize benefits to be paid directly to Brickworks Dental of New Jersey I understand that I am responsible for any unpaid balance.

_____ Date _____ Relationship to Patient _____
Signature of patient, parent or guardian

