

Joseph M. Micale DMD, PA
Individualized Comprehensive Dental Care
PATIENT REGISTRATION FORM

Date _____ Home Phone _____

Patient _____

First Name Middle Initial Last Name Preferred Name

Address _____

Street City State Zip

Birthdate _____ Age _____ Sex M F Single Married Child Other

Contacts: _____

Work Phone Cell Phone E-mail

Social Security # _____ Occupation _____

Employer Name _____

Business Address _____

Spouse Name _____ Occupation _____

Spouse Employer _____ Business Phone _____

Spouse Birthdate _____ Spouse Social Security # _____

Person responsible for this account? _____

In case of an emergency, who should be notified? _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____ Group Number _____

ID# _____ Policyholder is: Patient Parent Spouse Other

Please give card to front desk to be copied.

Please complete if policyholder is other than patient:

Name of Insured _____ Birthdate _____

SS# _____ Employer _____

Secondary Ins. Co. (if applicable): _____ Group Number _____

Name of Insured _____ ID# _____ Birthdate _____

Employer _____ Policyholder is: Patient Parent Spouse Other

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, and the billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions which will expedite the filing and processing of these forms on my behalf.

Date _____ Signature _____

(Patient, guardian or parent if minor)

MEDICAL HISTORY

Name _____ Date of Birth _____

Correct answers to the following questions will allow the doctor to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

Physician's Name _____ Phone () _____ Date of last physical _____

Check "yes" or "no" to indicate if you have or ever have had any of the following:

Acid Reflux/GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth (frequent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse (MVP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastro Intestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atrial Fibrillation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches (frequent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Habit	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug/Alcohol Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lymes Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you take Pre-med for Dental Appointments? Yes No Which antibiotic do you take? _____

Women: Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the corresponding diagnosis (including herbal meds & vitamins):

Specialist Physician's Name (e.g. Cardiologist, Oncologist, Orthopedic Surgeon): _____

ALLERGIES

Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Narcotic painkillers (e.g. codeine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin, Advil or Tylenol	<input type="checkbox"/>	<input type="checkbox"/>
Which antibiotics: _____			Latex	<input type="checkbox"/>	<input type="checkbox"/>

List any other allergies: _____

Have you ever had any adverse reactions to medical or dental treatment? _____

Is there anything else we should know about your medical history? _____

Signature: _____ Date: _____
(Patient, guardian, or parent if minor)

JOSEPH M. MICALE, D.M.D.

12 Ridge Street

Basking Ridge, NJ 07920

908-766-1515

DENTAL HISTORY

Name: _____ Today's Date: _____

Presenting Problem (if any): _____

• Describe any current discomfort/problem/concern with your teeth, gums, or jaw joint (TMJ):

• Previous dentist's name/address: _____

Date of last exam/cleaning: _____ May we request previous dental records? YES NO

Previous frequency of check-ups: 3mo 4mo 6mo other _____

Date of last x-rays: _____ Type: bitewings full mouth other _____

• Have you ever been treated for periodontal (gum) disease? (date) _____

• How do you feel about your smile? _____

• Have you ever bleached your teeth? YES NO

• Does dental treatment make you nervous? No Slightly Moderately Extremely

• How often do you floss? Daily Weekly As Needed

• How often do you brush each day? _____

• Do you use regularly (please circle)

mouthrinse	fluoride	rubber tip	waterpik
electric toothbrush	proxibrush	stimudent	other: _____

• Do you currently have (please circle):

bleeding, sore gums	unpleasant taste/bad breath	food impactions
frequent blisters	burning tongue/lips	change in bite
swelling/lumps in mouth	orthodontics (braces)	clenching/grinding
clicking/popping jaw	biting cheeks/lips	difficulty opening/closing jaw
loose teeth	tooth sensitivity: hot cold sweets biting	

IF COMPLETING DENTAL HISTORY FOR YOUR CHILD:

Is your child taking a fluoride supplement daily? YES NO DK

Is your drinking water fluoridated? YES NO DK

NOTE: When necessary and appropriate, we will apply fluoride, sealants, and take check-up x-rays for children. Indicate any of these procedures you do not give permission for:

Signature of Patient/Guardian _____ Dated: _____

Dear Patient:

Our office is committed to providing you with the highest quality dental care and most up-to-date information so that you may fully participate in attaining the best possible oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

- We require payment in full at the time of service, unless prior arrangements have been made.
- With the information your insurance company provides us, we will do our best to provide you an estimate of your co-pay prior to your appointment. Please read your insurance booklet and understand all waiting periods, frequency limitations, age limits, any exceptions and exclusions. If you are "double covered" with two insurance companies, be aware of the "duplication clause" and verify whether or not your secondary insurance has standard coordination of benefits, which may preclude you from receiving secondary coverage.
- As a courtesy, we gladly process your insurance and estimate the amount not covered by your insurance, this entire estimated co-pay is due at the time of service. All incurred charges are ultimately the responsibility of the patient regardless of the insurance coverage.
- Any balances over 30 days old may be subject to a monthly finance charge.

We require two business days notice for cancellations. Appointments canceled less than two working days notice and missed appointments may incur a fee.

I have read and understand the above financial and cancellation policy of our practice.

Signature: _____ Date: _____

Print Name: _____

Joseph M. Micale, D.M.D.

{NAME OF PRACTICE}

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: _____

Telephone: _____ Fax: _____

Address: _____

Email: _____

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.

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