Gina M. Tanios-Rafla, DMD
646 Highway 18, Suite 114
East Brunswick, NJ 08816
(732) 238-1760

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient# ___________________________

Date ______________________________

PATIENT INFORMATION

Name_______________________Birthdate______________________SS#________________________________
Address____________________City__________________________State_____Zip_________________________
Sex ☐M ☐F ☐Married ☐Widowed ☐Single ☐Minor
☐Separated ☐Divorced ☐Partnered for _____ years
Driver's License#____
Home Phone______________________Cell Phone______________Email______________________________
Preferred Method of Contact (please circle all that apply) Home Phone Work Phone Cell Phone Email
Employer____Work Phone___________________________
Employer Address_____________________________City_____________State____Zip_______________________

RESPONSIBLE PARTY

Person to contact in case of an emergency______________________________Phone#_________________________
Name of Person Responsible for this account___________________Relation to Patient_______________________
Address____Home Phone______________________________
Birthdate____Currently a patient in our office? ☐Yes☐No
Employer____ Work Phone_____________________________
Email____Cell Phone______________________________

How Did You Hear About Us?

Please Circle: Friend Relative Internet Yellow Pages Sign Other
Name of referral source (which friend, relative, etc)____

SPOUSE'S INFORMATION

Is Spouse a patient? ☐Yes☐No
Name____Birthdate__________________________________
SS#____________________________Work Phone_______________________Cell Phone_______________________
Employer Name____

INSURANCE INFORMATION

Primary Dental Insurance – Who is the insured? ☐Self☐Spouse ID#______________Group#____________________
Insurance Plan Name__________________________________Address______________________________________
City____________________________State_______ Zip____________ Phone_________________________________
Secondary Dental Insurance – Who is the insured? ☐Self☐Spouse ID#____________Group#____________________
Insurance Plan Name__________________________________Address______________________________________
City____________________________State_______Zip_____________Phone_________________________________

MEDICAL HISTORY

Patient Name______________________________________Age__________Date______________________________

Name of Physician_________________________________ Physician Phone________________________________

Date of last visit to physician_________________________Rate your general health ☐Poor ☐Fair ☐Good

PLEASE CHECK YES OR NO FOR THE FOLLOWING

YES	NO	Allergic reaction to:
☐	☐	Aspirin, Ibuprofen, Acetaminophen
☐	☐	Penicillin
☐	☐	Erythromycin
☐	☐	Codeine
☐	☐	Local anesthetic
☐	☐	Latex
☐	☐	Metals (gold, stainless steel)
☐	☐	any other medications:
☐	☐	Hospitalization for illness or injury
☐	☐	Artificial heart valve
☐	☐	Artificial joints
☐	☐	Implants
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Heart problems (murmurs, etc)
☐	☐	Heart disease
☐	☐	Chest pains / angina
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Low blood pressure
☐	☐	Dizziness or fainting
☐	☐	Pacemaker
☐	☐	Anemia / Bleeding disorder
☐	☐	Prolonged bleeding due to a slight cut
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Asthma
☐	☐	Respiratory problems
☐	☐	Sinus problems
☐	☐	Hay fever, hives, skin rash
☐	☐	Kidney disease
☐	☐	Liver disease
☐	☐	Jaundice
☐	☐	Thyroid or parathyroid problems

YES	NO	
☐	☐	Hormone / Endocrine problems
☐	☐	Diabetes
☐	☐	High cholesterol
☐	☐	Stomach / Digestive problems
☐	☐	Ulcers
☐	☐	Arthritis
☐	☐	Rheumatism
☐	☐	Glaucoma
☐	☐	Head or neck injury
☐	☐	Venereal disease / STD
☐	☐	Hepatitis (type)
☐	☐	AIDS / HIV
☐	☐	Tumor or abnormal growth
☐	☐	Cancer – if yes what kind?
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Mood disorder / Emotional problems
☐	☐	Nervous disorder
☐	☐	Psychiatric treatment
☐	☐	Antidepressant medication
☐	☐	Alcohol or drug dependency

ARE YOU:

YES	NO	
☐	☐	Being treated for any illness
☐	☐	Aware of a change in your health
☐	☐	Often exhausted or fatigued
☐	☐	A tobacco user
		Type____
		Amount/Frequency___________________________________
		Do you want to quit?
☐	☐	Considered a touchy person
☐	☐	Often unhappy or depressed
☐	☐	Easily upset or irritated
☐	☐	FEMALE – taking birth control pills
☐	☐	FEMALE – pregnant

Please describe any current medical treatment or impending surgery that may affect your dental treatment_______________________________
____

List **ALL Medications, Vitamins, Herbal Supplements,** or **Dietary Supplements you are currently taking**
____
____

Do you now or have you previously taken any of the following medications ☐YES ☐NO
Coumadin/Warafin, Plavix, Fen-Phen/Redux/Pondimin, Biophosphonates(Fosamax, Boniva, Actonel,Zometa,Aredia)

PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS IN THE FUTURE.

Patients Signature____ Doctor's Signature_______________________________________

DENTAL HISTORY

Previous Dentist____How long ago was last visit?__________________________________

What is your immediate dental concern?____

____

How often do you have your teeth cleaned? ☐3 months ☐4 months ☐6 months ☐1 year or more

How often do you brush your teeth? ___________________________Floss?_________________________

Rate your smile from 1 to 10 (with 10 being the best) _____________

YES	NO	PLEASE CHECK YES OR NO FOR THE FOLLOWING:
☐	☐	Would you like to discuss how to brush and floss properly
☐	☐	Are you unhappy with the appearance of your teeth/gums/smile?
☐	☐	Would you like to discuss how to make your teeth whiter?
☐	☐	Do you have sensitive or sore teeth?
☐	☐	Do your gums bleed?
☐	☐	Do you have an unpleasant taste or odor in your mouth?
☐	☐	Have you previously had treatment for gum disease (periodontal disease / pyorrhea)?
☐	☐	Have you previously had orthodontic treatment (braces)?
☐	☐	Do you currently wear any type of appliance?
☐	☐	Do you have jaw problems (TMJ problems)?
☐	☐	Do you have jaw clicking or popping?
☐	☐	Does your jaw ever lock?
☐	☐	Do you have difficulty opening your mouth widely?
☐	☐	Do you have tension headaches?
☐	☐	Do you have stiff neck muscles?
☐	☐	Do you awaken with an awareness of your teeth or jaws?
☐	☐	Are you aware of clenching or grinding your teeth?
☐	☐	Do you have a dry mouth?
☐	☐	Do you frequently have mouth sores (cold sores, canker sores)?
☐	☐	Have you lost any teeth?
☐	☐	Did you have any unfavorable dental experiences?
☐	☐	Do you have anxiety about dental visits?
☐	☐	Have you had any problems with effectiveness of dental anesthetic?
☐	☐	Do you have any lumps or swelling in your mouth?
☐	☐	Do you have difficulty swallowing or pain with swallowing?
☐	☐	Do you sweat or tremble a lot during examination?
☐	☐	Do strange people or places make you afraid?

SUPPLEMENTAL DENTURE HISTORY (Please fill out if you are wearing a partial or complete denture)

YES	NO	PLEASE CHECK YES OR NO FOR THE FOLLOWING:
☐	☐	Has your present denture been relined When?_______________________________________
☐	☐	Is your present denture a problem? Describe____
☐	☐	Satisfied with the appearance?____
☐	☐	Satisfied with the comfort? ____
☐	☐	Satisfied with the chewing ability?____
		When did you receive your first partial or complete denture? ______________________________
		How long have you worn your present denture?_______________________________________

Patients Signature__________________________________ Doctor's Signature______________________________________

Gina M. Tanios-Rafla, DMD

Laser Dentistry of New Jersey

FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, Mastercard, Discover and American Express.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.
- If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.
- We do not file claims for medical insurance.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A **$25** charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to **additional fees**. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least 48 hours in advance to avoid a missed appointment fee of up to **$50**. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your records or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Gina Tanios-Rafla, D.M.D. Without any reservations, I agree to abide by the policies outline herein.

_________ **I understand that the *LASER* fee is not a covered expense by the insurance Co.**

Form completed by:

Name___________________________________ Signature___________________________________

Relationship to patient if patient is a minor______________________________ Date_____________

Reviewed by staff member____ Date_____________