Print Form | Submit by Email

Allendale Dental

Welcome to our office! We are so glad you have chosen us to meet and exceed your dental expectations! Please take the time needed to complete our patient registration, especially the insurance information if you have not already given it to one of our team members.

Patient Name

☐ Married ☐ Single ☐ Child ☐ Other

☐ Male ☐ Female

Date

Address

SSN

City State Zip Code

Date of Birth

Email

Responsible Party

Home Phone

Relationship

Work Phone Cell Phone

Insurance Information

Subscriber SSN Date of Birth

Phone Number Employer

Relationship to Subscriber

☐ Spouse ☐ Child ☐ Other

Insurance Company

ID # Group #

Who may we thank for referring you to our office?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Direct Mail ☐ Insurance Company ☐ Newspaper

Name of person, office, or other source referring our office

Information and Consent Form

This form must be read and signed for legal consent of dental treatment. The information on this form in reference to any procedure used in our office is solely for your information. Any administration of anesthesia/analgesia will be discussed with you prior to dental treatment.

Consent for Treatment

I hearby grant the providers at Allendale Dental permission to provide my dental treatment. I understand that any treatment to be administered will be discussed with me first and all my questions will be answered.

I further understand that I may at any time request further consultation about any of the procedures used in this office.

Signature of Patient or Responsible Party:

Date:

Allendale Dental

Date

DENTAL AND MEDICAL HISTORY

Patient's Name | Chief Oral Complaint

Medical Physician's Name | Date of Last Visit Physician's

Please indicate with an "X" if you have or have had any of the following

- AIDS/HIV
- Autoimmune Disease
- Arthritis, Rheumatism
- Artificial Heart Valves/ HP
- Artificial Joints
- Asthma
- Bleeding Abnormally - Surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Congenital Heart Lesions
- Cough - Persistant/Bloody
- Diabetes
- Emphysema/COPD
- Epilepsy
- Fainting/Dizziness
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems/ Surgery
- Hepatitis
  - A B C D E
- Herpes
- High Blood Pressure
- Hip/Joint Replacement
- Jaw Pain
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Multiple Sclerosis
- Nervousness
- Osteoporosis / Osteopenia
- Pacemaker
- Pregnant (Currently)
- Psychiatric Care
- Radiation Treatment
- Reactions to Anesthetic
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Trouble
- Skin Rash
- Tobacco Use / Smoking
- Stroke
- Swelling of feet / Ankles
- Thyroid Problems
- Tuberculosis
- Tumor Growth on Head/Neck
- Ulcer
- Venereal Disease
- Unexplained Weight Loss
- Orthodontics
- Unfavorable Dental Experience

Allergies

- Aspirin
- Sulfa
- Local Anesthetic
- Penicillin
- Barbituates
- Latex
- Codeine

Other

Medications/ Surgeries

Please list any medications you are currently taking and Surgeries.

- **I am required to premedicate prior to dental appointments**
- I have taken Fen-Phen
- I currently use recreational drugs

Do you have a history of taking bisphosphonates (Prolia,Boniva, Didronel, Skelid, Aredia and Zometa Yes No

Patient's Signature or Parent/Guardian | Date

Doctor's Signature | Date

Our Commitment to You

We would like to take the opportunity to thank you for being an important member of our dental practice and to assure you of our continued commitment to excellence in providing dental care for you and your family. We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Treatment

Our goal is to build a long-term relationship with you and to help you in a relaxed and friendly environment. We are committed to providing you with a thorough and complete understanding of your dental condition, so that you can make an informed decision about you treatment. We want to assure you we will be with you every step of the way and welcome any questions you may have.

By initialing this section and signing below, you indicate that you understand and agree to these treatment guidelines.

Financial Arrangements **Initials:** _____

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash and credit cards (VISA, MasterCard, Discover, American Express and Care Credit). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion co-pays at the time treatment is rendered.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at time of service unless other arrangements have been made previously. Any additional balance on account-for any reason- after insurance payments have been received are my responsibility.

By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines.

Initials: _____

Appointments

We pre-plan and prepare for you visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed.

Should any scheduling changes be necessary, we require at least 48 hours advance notice during our normal business hours (Monday- Friday) to avoid a $50.00 per half hour rescheduling fee.

Courtesy Reminder Calls

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, pagers, and voice mails, some of our patients may not receive these reminder calls.

If we are unable to speak to you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines.

Initials: _____

We appreciate your understanding in our efforts to provide you with a positive experience.

Print Name of Patient or Responsible Party: _____ **Date:** _____

Signature of Patient or Responsible Party: _____

Allendale Dental

Assignment of Benefits Agreement for Allendale Dental

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. **The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company.** The following provisions identify our policies governing insurance claims.

Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. **By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.**

We require you to sign this agreement and /or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. All charges you incur are your responsibility regardless of your insurance coverage. We will inform you of any balance due after we receive payment from your insurance company. This must be paid within 30 days. We do not send monthly statements. **We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company.**

Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

Our practice will not enter into a dispute with your insurance company over a claim, although we will provide necessary documentation if your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of you insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

Returned checks are subject to a $25.00 fee. Balances older that 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our practice may charge you for appointments that you do not keep and for appointments that you do not cancel with a 48-hour notice at our discretion.

I have read and accept the terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to the practice.

Print Name of Patient or Responsible Party: _____

Signature of Patient or Responsible Party: _____ Date: _____

Allendale Dental

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. The rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other health care providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name of Patient or Responsible Party: _____ Date: _____

Signature of Patient or Responsible Party: _____

Sedation

In order to insure as pleasant and comfortable dental experience as possible, you may be receiving some form of sedative medication during your treatment. Usually the agent is Nitrous Oxide analgesia (laughing gas), and this is sometimes used in conjunction with other medications. For your comfort and safety **if Nitrous Oxide is to be used, please do not eat or drink for four hours before the appointment.**

This is not general anesthesia. You will remain conscious throughout the entire procedure. It is however, a level of sedation which will relax you and relieve anxiety to allow us to complete the planned dental treatment with as minimal an amount of psychic and physical trauma as possible.

If you have any questions concerning any aspect of your treatment, please inform us so that we may clarify the situation.

Print Name of Patient or Responsible Party: _____ Date: _____

Signature of Patient or Responsible Party: _____

Allendale Dental

42 West Allendale Ave, Allendale, N.J., 07401 tel: 201-760-1116 fax: 201-760-1134

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize ALLENDALE DENTAL, P.C. and providers thereof to render treatment and to release any medical information (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS) necessary to process claims, for any utilization review or quality assurance activities, or if and when applicable, as released verbally, written or by fax. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled for this or any other claim filed related to treatment received at ALLENDALE DENTAL, P.C. This assignment and authorization shall remain in effect unless revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that, even though I may have some type of insurance coverage, I am responsible for payment/co-payment of services. I understand that if this account is placed with a collection agency, I will be responsible for the collection fee in the recovery of this account. I further understand that as a person authorizing treatment for a minor, I am responsible for the charges incurred, regardless of other agreements in place. You agree to reimburse us the fees of any collection agency, Which may be based on a percentage at a Maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts.

By signing below, I am affirming that I have completed this form fully and that the information furnished is correct to the best of my knowledge. I am also affirming that I have read and understand the contents of the authorization above and my responsibilities therein. If I am insured by Medicare, I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration to its intermediaries or carrier, and information needed for this or a related Medicare claim whether verbal, written, or by fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits applied.

Allendale Dental is not responsible for determining if white or porcelain fillings are covered on posterior or back teeth. All restorations at Allendale Dental are made or done in composite or tooth colored unless otherwise notified by the patient and/or are not able to be placed in which case an amalgam or silver restoration will be placed. It will only be when the insurance company releases benefits to Allendale Dental that the billing department will know if the full cost of the restoration will be covered. Patients will be responsible for the cost difference between amalgam (silver) and composite (white) restorations.

_____ X _____

Patient Signature Date Person giving Consent/ Relationship to Patient Date