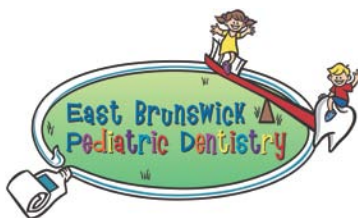

732-238-5100 17 Brunswick Woods Drive, East Brunswick, NJ 08816

Patient Information

Patient Name:____ Date: ___________
Last, First MI (Preferred Name)
Gender: _____________ Family Status: ______________
Social Security #: ______________________________ Birth Date: ____________________________
Phone (Home): ______________ (Work): _______________ Ext: ________ Mobile__________________
E-mail Address: ____

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________________ Reason for this visit: _________________________________

Has the patient ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies __________ __________	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due date:_________	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	OTHER:
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ ________________
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ ________________
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	

- Has the patient ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Has the patient been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Is the patient now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: _______________________________________ Phone: __________________
- Does the patient have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change in the patient's health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other Name of person or office referring you to our practice: ___________________________________

Patient's Name: ____

Spouse or Responsible Party Information:

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ________________________________Birth Date: ___________________________________

Phone (Home): ________________ (Work): ________________ Ext: ______ Best time to call: ______________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________________________ Occupation: _____________________________

Address: ____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: _____________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: _____________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Insurance Plan Name and Address: ____

Consent for Services

As a condition of treatment by this office, which may include the use of nitrous oxide, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. I understand that I am financially responsible for all costs of dental treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally/financially responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize release of any information relating to patients dental care. I authorize payments of all dental benefits, otherwise payable to me, directly to Jason Nudelman, DDS PC.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If account goes to collections, I understand that I am liable for all collection and/or attorney fees.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I also understand there will be a charge of $75 dollars for a missed appointment without 48 hours' notice.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to the content.

____ Date: _____________ Relationship to Patient: __________________

Signature of Patient/ Parent/ Guardian/ Responsible Party

East Brunswick Pediatric Dentistry 732-238-5100

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/PARENT/GUARDIAN/PERSONAL REPRESENTATIVE GIVING CONSENT

Name: ____
Address: ____
Telephone: ____ E-mail: _____________________________

SECTION B: TO THE PATIENT/ PARENT/GUARDIAN/PERSONAL REPRESENTATIVE — 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
East Brunswick Pediatric Dentistry Jason Nudelman, DDS East Brunswick, NJ 08816 (732)238-5100

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.

SIGNATURE

I, ________________________ (Parent/Guardian/Personal Representative) 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:** ____________________________

If a Parent/Guardian/Personal Representative signs this consent on behalf of the Patient please complete the following:

Print Name of Parent/Guardian/Personal Representative: ______________________________________

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

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: ___________________

Acknowledgement of Receipt
Notice of Privacy Practices
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. This document is printable via the web site for your records.
HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

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

____ ________________________
Signature **Date**

You May Refuse to Sign This Acknowledgement
For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

East Brunswick Pediatric Dentistry
www.eastbrunswickpediatricdentistry.com
17 Brunswick Woods Drive,   East Brunswick, NJ 08816
Phone: 732-238-5100   Fax: 732-238-0792

Dear Parent/Guardian of ____

We want to welcome you to our dental family. We pride ourselves in a family oriented environment. In order to provide your child with the highest quality of care please read the information below and ask any questions about anything you do not understand.

Anxiety Reducing Techniques
All effort will be made to obtain the cooperation of child dental patients by the use of Tell–Show-Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

Tell–Show-Do: The dentist or dental team explains to the child what is to be done using simple kid friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist finger. The procedure is then preformed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back or a prize.

Mouth Props/Rubber Dams: A mouth prop or "tooth pillow" as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc.) This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area to be worked on to isolate the teeth and prevents any debris from being swallowed or going to the back of the throat.

Immobilization by the Dentist: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child's hands or upper body, stabilizing the child's head between the dentist arm and body.

Immobilization by the Assistant: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child's hands, stabilizes the child's head and or legs.

Relaxation Gas: Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer/increase their attention span and allows the treatment to be completed in a comfortable manner for the child.

Insurance- Please understand that we accept insurance as a courtesy. We are happy to help with the process of submitting claims. However, understanding your insurance is ultimately your responsibility. The estimated out of pocket payment is due at the time of service.

Late and Missed Appointments- Please be aware that there is a charge of $75 dollars for a missed appointment without 48 hours' notice. Three missed appointments will result in discharge from our practice. In order to keep all our families on schedule, we ask you to be 10 minutes early to all appointments. We understand life gets busy however we value your time and we ask you to value ours as well as fellow patient families. If you are more than 10 minutes late, you may be asked to reschedule your appointment.

Copies of X Rays-We are always happy to provide you with copies of your child's X Rays. There is a charge of $25 dollars for all X Rays.

I________________________________ acknowledge that I have read the above and agree to the contents.

Printed name of Parent/Guardian/Representative

_________________________________ _____________________

Signature -- Parent/Guardian/Representative Date