Bay Dental Associates
654 Avenue C, Unit 202 Bayonne, NJ 07002
Tel. (201) 436-7777 Fax. (201) 436-7770

Patient Information

Name _____ (☐Male / ☐Female) SSN _____

Date of Birth (mm/dd/yy) _____ /_____ /_____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner

Address _____
Street Apartment # City State Zip code

Phone No. ▪ Home _____ ▪ Cell _____ ▪ Work _____

Email _____ May we contact you by email? ☐Yes ☐No

Emergency Contact _____ Phone _____

How did you hear about us? ☐Newspaper ☐TV ☐Radio ☐Internet ☐Referral ☐Other: _____

Dental Insurance Information

Subscriber Name _____ Relationship _____

Employer Name _____ Employer Phone _____

Insurance Company _____ Insurance Phone _____

Insurance ID No. _____ Insurance Group No. _____

Do you have an additional insurance? ☐Yes ☐No

Subscriber Name _____ Relationship _____

Employer Name _____ Employer Phone _____

Insurance Company _____ Insurance Phone _____

Insurance ID No. _____ Insurance Group No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Please answer the following medical history questions as correctly as possible.

Are you currently under the care of a physician? ☐Yes ☐No

Physician name _____ Phone _____

Have you ever had or currently have any of the following? Please check all that apply.

☐ Abscess	☐ Epilepsy / Seizures	☐ High / Low blood pressure	☐ Rheumatic fever
☐ Allergies to drugs	☐ Eye disorder	☐ HIV infection	☐ Sinus problems
☐ Allergies to anesthetics	☐ Fainting	☐ Kidney disease	☐ Skin rash
☐ Anemia	☐ Fay fever	☐ Liver disease	☐ Stomach problems
☐ Artificial joints	☐ Glaucoma	☐ Mental disorders	☐ Stroke
☐ Arthritis, Rheumatism	☐ Headaches	☐ Neurological problems	☐ Thyroid problems
☐ Asthma	☐ Head injuries	☐ Organ Transplant	☐ Tonsillitis
☐ Bleeding disorder	☐ Heart disease	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Heart murmur	☐ Pace maker	☐ Ulcer / Colitis
☐ Chemical dependency	☐ Hemophilia	☐ Pregnancy Month _____	☐ Venereal disease
☐ Chemotherapy	☐ Hepatitis (☐B / ☐C)	☐ Radiation treatment	☐ Other
☐ Diabetes	☐ Hernia repair	☐ Respiratory disease	

Are you allergic to:

☐Aspirin ☐ Codeine ☐ Latex (rubber) ☐Local Anesthetics ☐Narcotics ☐Penicillin ☐Sulfa Drugs ☐Other

Do you have any conditions that are not listed above that we should know about?

_____

List medications you are currently taking and the correlating diagnosis:

_____

List all complications or allergic reactions if you have or have had any.

_____

Has your doctor told you to take antibiotic medication before dental treatment? ☐Yes ☐No

Do you take a bone-building drug? ☐Yes ☐No

Are you nursing? ☐Yes ☐No Are you taking oral contraceptive? ☐Yes ☐No

X-rays can cause fetal development problems and some antibiotics can effect birth control efficiency. Initial____

_____ Date_____

Signature of patient / parent or guardian

Dental History

Have you ever had or currently have any of the following? Please check all that apply.

- ☐ Abnormal bleeding after dental care
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Brushing Frequency: _____
- ☐ Clenching or grinding
- ☐ Clicking or popping jaw
- ☐ Cough up blood
- ☐ Cold / Canker sores or blisters
- ☐ Complication from extraction
- ☐ Dental Floss Frequency: _____
- ☐ Disclosing tablets or solution
- ☐ Dry mouth
- ☐ Fluoride supplements
- ☐ Food impaction
- ☐ Frequent snacking
- ☐ Gag easily
- ☐ Inter dental stimulations
- ☐ Jaw pain
- ☐ Loose or broken fillings / teeth
- ☐ Mouth breathing
- ☐ Oral habits, i.e. suck thumb
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Receding gums
- ☐ Sensitive / sore gums
- ☐ Sensitive to hot / cold
- ☐ Sensitive to pressure
- ☐ Sensitive to sweets
- ☐ Swelling or lumps in mouth
- ☐ Texture of tooth brushing _____
- ☐ Tobacco habit / smoking
- ☐ Toothaches
- ☐ Unfavorable dental experience
- ☐ Unpleasant taste
- ☐ Unusual sounds in ear while eating
- ☐ Water jet device
- ☐ Other

Any previous dental treatments? ☐Yes ☐No If Yes, when & what _____

Chief oral complaint _____

Reason for today's visit _____ Date of last dental visit _____

Additional interest in ☐Whitening ☐Bonding ☐Veneers ☐Crowns ☐Invisalign ☐Night guard

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

_____ Date_____

Signature of patient / parent or legal guardian

Authorization

I authorize the disclosure of information from my treatment records to:

Name of Recipient _____ Relationship _____

I give authorization to disclose the following information:

☐ All treatment information ☐ Specific Date: _____ ~ _____

I understand that I may withdraw or revoke my permission at any time with written words.

_____ Date_____

Printed name & signature of patient / parent or legal guardian

INFORMED CONSENT

1. **Dental Examination and Treatment Plan**
   Law requires that the dentist examine and diagnose all new prior to delegating general supervision duties to auxiliaries including hygienist for cleaning. INITIAL _____
2. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations. For example, root canal therapy may follow routine restorative procedures. I give my permission to the dentist to make any and all changes and additions as necessary, after explaining the reason and obtaining my consent. INITIAL _____
3. **Drug and Medications**
   I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and, or anaphylactic shock. INITIAL _____
4. **Periodontal Loss**
   I understand that periodontal disease is a condition of the gums and bone and it can lead to eventual tooth loss. Alternative treatment plans have been explained to me, including scaling, root planning, medicinal irrigation and gum surgery replacement and / or extraction. I understand that undertaking any dental procedures may not prevent continued bone loss. I understand that I may require constant maintenance. INITIAL _____
5. **Fillings**
   I understand that care must be exercised in chewing on new fillings especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. INITIAL _____
6. **Crowns, Bridges and Caps**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. Endodontic (root canal) may be necessary after or during crown cementation. INITIAL _____
7. **Endodontic Treatment (Root Canal)**
   I realize there is no guarantee that root canal treatment will save my tooth and that complication can occur from the treatment and that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoetomy). I understand that the tooth may be lost despite all efforts to save it. IN some cases, a preciously treated tooth should be restored as soon as possible to protect it from fracture or decay. INITIAL _____
8. **Removal of Teeth**
   Alternative to removal have been explained to me (root canal therapy, crown and periodontal surgery, etc.). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. INITIAL _____
9. **Dentures**
   I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjustment and several relines. A permanent reline will be need later. This is not included in the original denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. INITIAL _____
10. **Cosmetic services**
    Cosmetic services may not be covered by insurance plans. This includes porcelain facings on molars, cosmetic bleaching, cosmetic bonding and laminated (veneers). INITIAL _____
11. **Optional Treatment (Bone Graft & Sinus Lift)**
    The need for treatment that is excluded as a benefit by insurance has been explained to me. If I choose to proceed, the use and cost of noble metals, including gold, will be with my consent. INITIAL _____

I hereby authorize any of the doctors to proceed with and perform the dental restorations and treatments explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. Should any dispute arise over dental services provided to me, that is whether any dental service rendered was allegedly unnecessary, unauthorized or was improperly, negligently or incompetently performed said dispute will be submitted to peer review by the dental society, a component of the American Dental Association, the decision of peer review shall be binding on both parties. I have read, understood and agreed to everything above numbers 1-11.

_____ Date_____

Signature of patient / parent or legal guardian

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 INFORMATIONS. PLEASE REVIEW IT CAREFULLY.
THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with your health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, and payment for healthcare operations. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.
Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information and postage if you want the copies mailed to you.

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 you disagree with decisions 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 contract 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 US Department of Health and Human Services upon request.We support you right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.
A Privacy / Contract Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy / Contract Officer.

PATIENT ACKOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

_____ Date_____
Signature of patient / parent or legal guardian

I,_____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES as
(Print Name of Patient)
required by federal law and I consent to the use and disclosure of my personal health information by your office during Treatment, Billing / Payment and Healthcare Operations as outlined in the Notice of Privacy Practices.

PATIENT CONSENT FOR SERVICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 healthcare providers involved in my treatment)

Obtaining payment from third party payers (let my insurance company)

Upon my request I may secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information, and my rights under HIPAA. 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 those 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 revoked this content is not affected.
I have read and agree to the terms in this CONSENT FOR SERVICES

_____ Date_____

Signature of patient / parent or legal guardian

OFFICE FINANCIAL POLICY

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance benefits be paid directly to BAY DENTAL ASSOCIATES and I understand that I am responsible for the payment of deductibles, copayment, and any balances not covered by my insurance. I further understand that fees for professional services rendered are payable in full within 30 days. A service charge of 1% per month will be added to all account balances for 60 days old, this is an annual rate of 12%. I understand that if my account becomes delinquent, I may be referred to a third party for collection. If this should be turned over to collections, there will be a $75 processing fee applied to the balance. I also understand that future dental services may be limited for all persons under my account until my account is current. I also authorize BAY DENTAL ASSOCIATES to release any information required to process my claims. I understand that payment is due at the time of service. All confirmed appointments that are NOT cancelled within 24 hours of the appointment time will be charged a $35.00 late cancellation fee. All confirmed appointments that are a no show will be charged a $35.00 absent fee. I understand that there is $50.00 fee for releasing dental records and xrays. I also understand there is a separate fee of $200.00 for a CT.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are changed directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. Upon receipt of full (or partial) payment of bill. We do not render our service on the basic that insurance companies will pay all our fees. Each fee is individual for the individual patient.

I have read and agree to the terms in this OFFICE FINANCIAL POLICY.

_____ Date_____

Signature of patient / parent or legal guardian