The Center for Dentistry
Located at
Hackensack University Medical Center

Hackensack
Meridian *Health*
Hackensack University
Medical Center

DENTAL CENTER RULES

All patients must know that The Center for Dentistry is a Residency Program where all patients will be attended by a Resident, who is in a Post Graduate Training Program, with other clinical students that may participate in their care.

1. Be sure to confirm your appointment at least 2 days in advance. **We do not guarantee appointments that are not confirmed**. Please remember for every appointment you do not make, another patient's treatment is delayed.
2. If you are more than 15 minutes late, we cannot guarantee that you will be seen. If this happens more than three (3) times, you will not be given another appointment.
3. We require 24 hours notice of cancellation. **Failure to notify will result in a $25 cancellation fee.**
4. If you cancel twice without sufficient cause, you will not be rescheduled. If there are valid reasons for these cancellations that you can document, you will be given one additional appointment. If you simply do not show up or fail to notify the Dental Clinic that you cannot make your appointment, you will not be given any additional appointments. *Special consideration will be given for documented emergencies.*
5. **Identification Standard**: Two forms of valid proof are required (both must feature the same address):
   - Valid Driver's License or state/county issued photo identification card with current address
   - Public Service bill with guarantor's name issued within the last 60 days.
   - Bank statement with guarantor's name issued within the last 60 days.
   - Passport
6. **Payment is due at the time of service. We accept Cash, Check, Visa, Mastercard, American Express and we offer financing through Care Credit Card. Please note, any check(s) returned for insufficient funds will result in a $35 insufficient funds fee.**

I certify that I have read the above information:

_____ _____

(Signature of Patient/Guardian) (Date)

_____

(Print Patient Name)

30 Prospect Ave.
Hackensack, NJ 07601
551-996-2111

60 Second St.
Hackensack, NJ 07601
551-996-3519

PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT)

Patient_____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____ Alt. Phone (_____)_____ Email address:_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____

Employer Address _____ Work Phone (_____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation_____

Employer Address _____ Work Phone (_____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security # _____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____)_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ HIV / AIDS or Other Immunosuppressive Disorders
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, please describe _____

_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

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

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated?		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain		
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5. (Women) Are you pregnant? If so, give due date	☐	☐
6. Do you use tobacco in any form? If yes, how much	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐

8. Do you have or have you ever had any of the following?

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Latex sensitivity	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV+	☐	☐
AIDS	☐	☐

Please complete reverse side

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

	YES	NO
Local anesthetics (e.g. novocaine)	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐
Penicillin/other antibiotics	☐	☐
Aspirin or codeine	☐	☐
Sulfa drugs	☐	☐

Other allergies _____

10. Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medicine	☐	☐
Cortisone/steroids	☐	☐
Antihistamines/allergy drugs/ cold remedies	☐	☐
Tranquilizers	☐	☐
Insulin/other diabetes drugs	☐	☐
Recreational drugs	☐	☐
Digitalis/other heart medications	☐	☐
Nitroglycerin	☐	☐
Aspirin	☐	☐

Other medication _____

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

14. Does dental treatment *make* you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15 Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue/lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling/lumps in mouth	☐	☐
Ortho treatments (braces)	☐	☐
Biting cheeks/lips	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

TEETH

	YES	NO
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching/grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐

Other _____

How often do you brush _____

Brush is: Soft ☐ Medium ☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian _____ Date _____

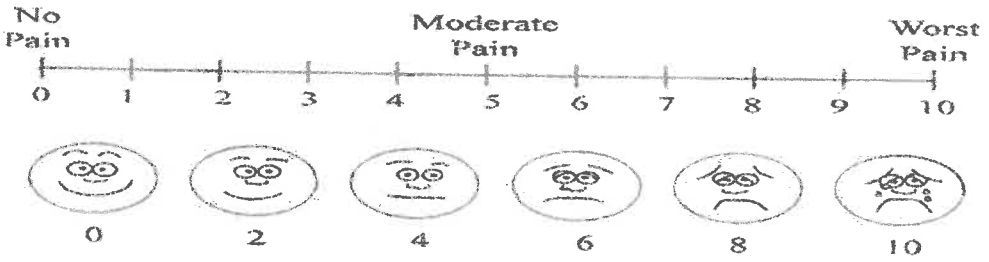
THE CENTER FOR DENTISTRY AT HUMC
PAIN MANAGEMENT PATIENT QUESTIONNAIRE

To serve your care needs better, please take a few minutes to complete this questionnaire. When you are finished, please return the questionnaire to the front desk. Thank you so much for your assistance with our survey.

1. Are you currently experiencing pain on a recurring basis?

◯ YES ◯ NO

Using the pictures/numbers below, circle the picture/number that best describes your pain.



(If your answer is "Yes," continue; if "No," you may stop here.)

2. If "Yes," is your pain:

◯ **Intermittent?** ◯ **Constant?**

3. Are you taking medication(s) to control the pain?

◯ **YES** ◯ **NO**

4. If "Yes," is it over the counter (OTC) or prescribed by your doctor?

_____

5. Has anyone dicussed the importance of receiving pain relief with you?

No one My Doctor A Nurse Other: _____

6. How satisfied are you with the way your pain in controlled at this time?

Very Satisfied Satisfied Dissatisfied Very Dissatisfied

7. If you are using medication(s) for controlling your pain, please **LIST** them:

_____

_____

8. If you are not receiving pain relief, have you been given instructions on who to call?

_____

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Payment Policy

PAYMENT IN FULL: Full payment is required at the time of service from all patients.

DENTAL INSURANCE: We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any estimated coverage. Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for all charges. If for any reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

PAYMENT OPTIONS

- **CASH or Money Order**
- **CREDIT CARDS:** For your convenience, we accept payment by MasterCard, Visa, American Express, and Care Credit.
- **PAYMENT PLANS:** For patients who desire a monthly payment plan, we offer financing through Care Credit. There are no application fees or down payment and the loan can be interest-free. Applications are available from our office and approval is provided quickly.

PAST DUE BALANCES: A past due balance is any amount owed from a prior visit where insurance is not pending or an insurance payment has not been received within 60 days. All unpaid balances are subject to a 1.5% monthly service charge. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

RED FLAG RULE: The Red Flag Rule was created by the Federal Trade Commission, along with other government agencies such as the National Credit Union Administration, to help prevent identity theft. The rule was passed in January 2008. In order to comply with this rule, our office will be requiring the following information in order to be treated in our facility.

1. All new patients will be required to present a valid photo identification card issued by a local, state or federal government agency, and we shall copy said identification to keep in our files: a. In the case where the new patient is a minor, photo identification of the patient's responsible party will be obtained; and b. In the case where a new patient does not have a valid photo ID, two forms of non-photo identification, one of which is issued by a state or federal agency, will be obtained as well as a water or utility bill or other form identifying the correct or current address.

2. For new patients with insurance, information will be verified with their insurance company prior to billing.

3. **If a Patient/Guarantor does not have two of the approved forms of identification listed above, the elective service will need to be re-scheduled.**

Patient Signature: _____ Date: _____

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Information (HIPPA) Release Form

Patient name: _____ DOB: _____

Release of Information

I authorize the release of information including: diagnosis, records, and insurance information. This information may be released to:

- ○ Spouse: _____
- ○ Children: _____
- ○ Parent/Guardian: _____
- ○ Other: _____
- ○ Self: _____
- ○ Information is NOT to be released to anyone.

Messages:

Please call:

- ○ My home: _____
- ○ My workplace: _____
- ○ My mobile: _____

If unable to contact me, you may:

- ○ Leave a detail message
- ○ Leave a message requesting a call back

The best time to reach me is:

- ○ Morning
- ○ Afternoon
- ○ Evening

Signature: _____ Date: _____

Witness: _____ Date: _____

60 2nd Street
Hackensack NJ 07601
T. 551-996-2111
F. 551-996-0819

30 Prospect Ave
Hackensack NJ 07601
T. 551-996-2111
F. 551-996-2334