

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 DOB: _____ Male Female SS#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____
 State ID/Driver's License #: _____ E-mail Address: _____
 Name of Physician: _____ Physician Phone: _____
 In case of Emergency Contact: _____ Relationship: _____ Phone: _____
 How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____			Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Medical Questions

List any medications you are taking including nonprescription drugs: _____

 Do you have any disease/problem you think we should know about? YES No

Are you allergic to any medications? YES No If yes, please list below:

Are you in good health? YES No

Date of last medical exam: _____

Have you ever been hospitalized? YES No If yes, what was the problem

Have you had a transplant operation that has depressed your immune system? YES No

Have you had an allergic reaction to Bananas? YES No

Do you smoke or chew tobacco? YES No

Have you had Heart Surgery? YES No

Are you now under the care of an MD? YES No

Are you taking or have you ever taken bisphosphonates?
 (Fosamax or Actonel for osteoporosis, chemotherapy, etc) YES No

FOR WOMEN ONLY:

Are you taking birth control pills? YES No

Are you nursing/breastfeeding? YES No

Are you pregnant? YES No

Expected delivery date: _____

Is there a possibility of pregnancy? YES No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Dental History Information

Date of last dental visit? _____

Do you snore? YES No

Name of your previous dentist _____

Do you have problems with bad breath? YES No

Reason for today's visit? _____

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? YES No

Have you ever had an oral cancer screening? YES No

Have you ever used an electric toothbrush? YES No

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure? YES No

Do your gums bleed when you brush? YES No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Have you ever had complications from an extraction? YES No

If you could change something about your smile what would it be:

Have you ever had a popping or clicking near your ear when you chew? YES No

Whiter

Are you prone to frequent headaches? YES No

Straighter

Do you grind or clench your teeth? YES No

Close space

Do you have sores, blisters or swelling on your gums lips or cheeks? YES No

replace black mercury filling with tooth colored restorations

repair chipped teeth

Have you ever had orthodontic treatment? YES No

replace missing teeth

less gums showing

replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

Date:

Dr. Signature:

Date:

Reviewed by:



HIPAA NOTICE OF PRIVACY PRACTICES

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at anytime before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) will be updates whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I ACKNOWLEDGE THAT I HAVE RECEIVED THE *Notice of Privacy Practices* FROM NU FAMILY DENTAL.

Signature: Printed Name: Date:

Phone Number: Patient Address

Patient or Authorized Representative



1 Kathleen Drive Jackson, NJ 08527
(732)363-6633 nufamilydental@gmail.com

DISCLOSURE DESIGNATION OF RELATIVES AND/OR OTHER CAREGIVERS

I agree that NU Family Dental may disclose certain of my health information to a family member and/or caregiver, since such person is involved with my health care or payment relating to my health care. In that case, NU Family Dental will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I wish to be contacted in the following manner (please check all that apply):

You can disclose my health information as described below:

- 1. OK to leave message(s) with detailed information at my home number and/or mobile number
- On my answering machine
- With my spouse
- With anyone answering the phone
- Leave message with call back numbers only
- 2. OK to leave message(s) with detailed information at work number(s)
- Leave message with call back numbers only
- 3. OK to fax information to this number
- 4. OK to email. Email Address
- 5. OK to text to my mobile number

The following persons are authorized to receive my Patient Health Information:

Name:	<input type="text"/>	Relationship:	<input type="text"/>		
Name:	<input type="text"/>	Relationship:	<input type="text"/>		
Signature:	<input type="text"/>	Printed Name:	<input type="text"/>	Date:	<input type="text"/>

Patient or Authorized Representative



PATIENT RESPONSIBILITY

1. We have a personal, professional, and ethical responsibility to care for your dental health to the best of our abilities. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevents achieving the goal of optimum dental health for you. Therefore, our office appointment policy must be agreed upon. **No-shows are not acceptable.** Failure to keep an appointment compromises your dental health. If you cannot keep an appointment, (except in the case of an emergency) you are required to call within 24 hours of your appointment to reschedule. There is a strict office policy on **broken appointments. A charge of \$35.00 will be applied for the first offense. A following offense will result in a charge of \$55 per 40-minute period of appointment.** This fee is not covered by insurance. **Any appointments wherein there is no patient present 15 minutes or more after the scheduled time without prior notice, will be rescheduled and the broken appointment fee policy will apply.**
2. INDIVIDUAL'S FINANCIAL RESPONSIBILITY
 - a. My insurance policy is a contract between me and my insurance carrier. Therefore, it is my responsibility to know my benefits.
 - b. I understand that I am financially responsible for my health insurance deductible, coinsurance or any non-covered service(s).
 - c. Patients with third/tertiary insurance plans will be responsible for all copays according to that plan as well as submission for reimbursement.
 - d. Co-payments are due at time of service(s).
 - i. Any copayments not paid on the date of service are subject to an automatic late fee of \$15 per day lapsed applied to the patient account balance.
 - e. If my plan requires a referral, I must obtain it prior to my visit.
 - f. In the event that my insurance plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.
 - g. If I am uninsured, I agree to pay for the dental services rendered to me at time of service.
 - h. Credit card transactions require a minimum charge of \$20.00.**
 - i. CareCredit transactions require a minimum charge of \$1000.00.**
 - j. There will be a billing fee of \$10.00 for any unpaid copays at the time services are rendered.**
 - k. In the unfortunate event where an unpaid account balance must be sent to a collection agency, the collection processing fee will be added onto the account balance.**
3. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
 - a. I hereby authorize and direct payment of my medical benefits to NU FAMILY DENTAL on my behalf for any services furnished to me by the providers.
4. AUTHORIZATION TO RELEASE RECORDS
 - a. I hereby authorize NU FAMILY DENTAL to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnoses and records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical providers.

Signature: _____

Patient or Authorized Representative

Printed Name: _____

Date _____



NU FAMILY DENTAL

CONSENT TO ROUTINE DENTAL TREATMENT

I hereby request and authorize NU Family Dental to perform dental treatment for one or more of the following conditions: dental decay, gingivitis, periodontitis (gum problems), malocclusion, acute pulpitis (disease of the nerve of the tooth), trauma, or any other oral conditions or diseases.

The procedure(s) necessary to treat the condition(s) have been explained to me, and are listed on the treatment plan. Alternative treatment plans have also been explained to my satisfaction.

The risks and benefits of the preferred treatment plan and alternative treatment plan have been satisfactorily explained to me. In addition, the doctor has explained the risks of not having any dental procedures performed. Such risks include severe dental infections severe gingival (gum) infections, and the premature loss of teeth.

I understand that unforeseen conditions or circumstances may arise during the course of the above described procedure or treatment; hence, I consent to and authorize the performance of any care, procedure or treatment not specified above that the dentist reasonably believes necessary or advisable as a result to these unforeseen events.

Additionally, I consent to the administration of any local anesthetic that the dentist deems necessary. I understand that the risks involved with the administration of local anesthetics include, but are not limited to: nerve injury causing temporary or permanent numbness of the lower lip, chin or tongue area, infection, stiffness of the jaw (trismus), bleeding and/or bruising, allergic reaction.

It has been explained to me, and I understand, that a perfect result is not and cannot be guaranteed.

In accepting care, patients warrant that they will: (a) follow home care instructions (b) keep appointments, or notify the office at least 24 hours in advance if they cannot be kept (c) pay for services in a timely agreed upon fashion (d) cooperate with the dentist in their care (e) give honest answers to all questions related to their histories (f) notify the office (dentist) if their health status has changed, or if their physician has placed them on new medication.

Patient, Parent or Guardian

Date

Dentist

Witness



NU FAMILY DENTAL

Radiograph Policy

X-rays provide one of the best diagnostic tools in dentistry. They enable the dentist and hygienist to see inside the tissue of the teeth, gums and bones of the jaw. We assure you that we are conservative in our use of x-rays, but without them decay and other diseases of the teeth and mouth often cannot be diagnosed until serious damage has been done. We never take unnecessary x-rays.

It is recommended that radiographs be taken at regular intervals for patients with no signs of decay or disease, and for diagnostic purposes when indicated. A full mouth series is needed every three to five years, alternating with a panoramic film, as well as four bitewing and two anterior periapical x-rays every six months.

Our policy at NU Family Dental is that check-up x-rays be taken twice a year in order to properly diagnose any oral conditions (decay, cysts, abscessed teeth, tumors, bone loss, or any other condition not otherwise mentioned). In limited circumstances we will allow patients to receive check-up x-rays once a year. However, if any of our dental professionals visibly sees what we believe to be an oral condition we will recommend a radiograph of the suspicious area.

Some dental insurance plans have limits on their coverage of radiographs. If you have dental insurance, please check your policy's coverage.

I acknowledge that I have read and understand the radiograph policy of NU Family Dental.

Signature

Date

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: _____ (“patient”)

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to \$35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney’s fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

Secondary Insurance:

Secondary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

I acknowledge having received a copy of the Practice’s Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ Date: _____

(to be signed even if Patient is also the Responsible Party)

NU Family Dental Credit Card on File Authorization & Consent Form

Purpose of This Form

To provide a smooth and efficient checkout process, NU Family Dental securely stores a patient's credit or debit card on file for future payments related to dental treatment, copayments, deductibles, and any balances not covered by insurance. All card details are stored through a secure, PCI-compliant, encrypted payment platform. Our office does not keep full card information internally.

Patient Information

Patient Name: _____

Phone Number: _____

Email: _____

Authorization to Maintain Card on File

By signing below, I authorize NU Family Dental to securely store my credit or debit card information for use in processing payments for:

- Insurance copays, deductibles, and coinsurance
- Remaining balances after insurance processes a claim
- Approved treatment completed during future visits
- Cancellation or no-show fees, if applicable

I understand the following:

1. My complete card details are encrypted and cannot be viewed by any team member.
2. I will receive an itemized receipt for any charges made to my card.
3. I will be notified before any transaction is processed. Notification will be sent via phone, text, or email using the contact information on file.
4. If I do not respond or make payment within 24 hours of the notification, NU Family Dental is authorized to automatically charge my card on file for the balance due.
5. A \$2.00 pre-authorization will be used only for initial card verification and will be refunded.
6. I may change my card at any time.
7. I am responsible for maintaining updated card information if my card number, expiration date, or billing address changes.
8. This authorization remains active until I revoke it in writing.

HIPAA-Compliant Privacy Statement

NU Family Dental protects your health and financial information in accordance with federal privacy regulations (HIPAA). Your credit or debit card information is stored only within a secure, encrypted, PCI-compliant processing system and is never retained in your dental records or office files. Your financial information will be used solely for payment of dental services and related balances. It will not be shared, disclosed, or used for any other purpose unless required by law or authorized by you in writing. Access to this information is limited to personnel involved in patient billing and account management.

Cardholder Agreement

I certify that I am the authorized cardholder of the payment method to be stored. I authorize NU Family Dental to process charges to this card according to the terms outlined above.

Card Type (circle): VISA / MasterCard / AMEX / Discover

Circle One: Debit or Credit

Last 4 digits of card: _____

Preferred Method of Notification (Circle): Text Email Phone

Signature

Cardholder Name (print): _____

Signature: _____ Date: _____

****Please have your card present in the office with you to initially enter information into our system.****