Perfect Smiles Dentistry, LLC
Location 1: 101 S. White Horse Pike, Lindenwold, NJ 08021
Location 2: Pavilions at Greentree, 651 Rt 73 N. Suite 208, Marlton, NJ 08053
www.PerfectSmilesDentist.com
info@psdnj.com

Dental Registration and History Form

1. PATIENT INFORMATION

Patient Name: _____
Last Name First Name Middle Initial

Date: _____ Birthday: _____
SS#: _____ Sex: ☐ Male ☐ Female
Insurance ID #: _____ Driver Lic#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Tel: _____ Work Tel: _____
Mobile #: _____ Occupation: _____
Email: _____ Marital Status: _____
Referral Source: _____
Notes: _____

☐ I would like to receive correspondence/office specials via email.

2. EMPLOYER / SCHOOL

Employer / School Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Notes: _____
_____

2. EMERGENCY CONTACT

Emergency Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Mobile#: _____
Relationship: _____

4. INSURANCE INFORMATION

Responsible Party Name: _____
Relationship to Patient: _____
Insurance Company: _____ Tel: _____
Subscriber Name: _____
Group #: _____SS#: _____
Birthday: _____ Other Coverage: ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:
_____
and assigned directly to Perfect Smiles Dentistry all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather or not paid by the insurance. I authorize the use of my signature on all insurance submissions. Perfect Smiles Dentistry may use my health care Information and may disclose such information in the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____

5. DENTAL HISTORY

Reason for today's visit: _____
Former Dentist: _____ Tel: _____ Last X-Ray Date: _____
Do you feel pain: ☐ Yes ☐ No if yes, please describe: _____
Do you like your smile: ☐ Yes ☐ No If No, please explain: _____
Do you Smoke: ☐ Yes ☐ No If Yes, How many cigarettes per day: _____
Additional comments about your past dental history: _____
_____

Dental Anxiety or Fears about being treated in the dental office. Rate on scale 1 to 10 with 10 being extremely frightened and uncomfortable:

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

CHILD:

Any Habits? ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Mouth Breathing ☐ Lip Sucking/Biting
☐ Other: _____

SAVE RESET

Please continue to 2nd page

Dental Registration and History Form Page 2

6. MEDICATIONS & ALLERGIES

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If Yes, please explain: _____
Have you ever been hospitalized or had a mjaor operation?	☐ Yes	☐ No	If Yes, please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If Yes, please explain: _____
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	If Yes, please explain: _____
Do you take, or have you taken, Phen- Fen or Redux?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	
Women: Are you			
Pregnant/Trying to get pregnant?	☐ Yes	☐ No	
Taking oral contraceptives?	☐ Yes	☐ No	
Nursing?	☐ Yes	☐ No	

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetics ☐ Other ☐ If yes, Please explain: _____

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B/C ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anaemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy/Seizures ☐ Yes ☐ No	Hives/Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Value ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem Bruise ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitra! Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors /Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores & Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker Heart ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Trouble/Disease ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	Past / Present Use of Drugs ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes. please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ Date: _____

Authorization, Release and Financial Responsibility:

Payment is due in full at the time of treatment unless prior arrangements have been approved by the doctor.
This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment I hereby authorize the release of any information, Including the diagnosis and records of treatment or examination rendered, to my Insurance company. I understand that the information that I have given today Is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

SIGNATURE OF PATIENT, PARENT , or GUARDIAN: _____ Date: _____

SAVE PRINT
RESET SEND

PERFECT SMILES DENTISTRY

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MISSED APPOINTMENT POLICY

To All Our Patients

Delivering quality dental care is most important to us. In order for our limited number of doctors to serve a rapidly growing patient population, we must have rules and regulations at this center to ensure that all of our patients receive the best and the timeliest dental care that we can deliver. For this reason, we have instituted a "missed appointment "policy which has helped us to see more patients and make more productive use of our time.

What is a "missed appointment"? We consider it a missed appointment.

- If you cancel an appointment with us less than 24 hours before the appointment time.
- If you do not arrive for your appointment.
- If you arrive at your appointment more than 15 minutes late.

Missed appointments will require us to schedule your dental appointments at times that might not be as convenient for you. If you miss more than two (2) appointments, we will have to ask you to seek your dental care elsewhere. Please understand that in no way are our policies intended to create problems for anyone. We need them to help our doctors best serve our patient population as a whole.

Please make every effort to schedule appointments at times when you feel you can keep them to arrive at appointments on time, and if you have to cancel an appointment to call more than a day ahead.

LATENESS POLICY

If you are late (up to 15, minutes) for your scheduled dental appointment, we will try to fit you into the schedule but please remember that we have many emergency patients we see each day. Your doctor may have taken an emergency in your place and we will take you when he or she is finished treating the emergency.

If you are 15 or more minutes late for any reason you will not be seen for that appointment. Please understand that we must enforce this policy, or our doctors will run behind with their appointments inconveniencing our scheduled patients our staff and faculty.

TREATMENT OF MINORS

All minor patients (less than 18 years old) MUST be accompanied to the appointment by a parent or other legal guardian, Grandparents, other adult relatives or adult friends who are not legal guardians are not acceptable for this. Our doctors are advised to ask all adults who come with minors if they are legal guardians of these minors if they are not the minors will not be treated even for a "new patient" appointment.

In addition all legal guardians must stay on the premises for the whole appointment. If the guardian leaves the building we will have to stop the dental treatment for that clay. Please understand that we must enforce this policy as required by law, and we apologize if this causes an inconvenience for anyone.

I have read the above policies and understand that by cooperating with these policies, I can help the staff of the DENTAL OFFICE provide the best possible care for myself and for other patients in the community.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWKEDGEMENT AND CONSENT FOR TREATMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in the writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that from the physical design of the office that I may overhear personal information and I will not discuss it with anyone.
I also consent for Dr. Julka or a staff member to take X-rays, study models, photographs, or any other diagnostic aid deemed appropriate by Dr. Julka to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Julka to perform any and all forms of treatment, medication and therapy that may be indicated.

Patient Name

Relationship to Patient

Signature

Date

For Office Use Only: 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 acknowledgment.
Others (Please Specify)