Clinton Center Dental

clintoncenterdental.com
info@clintoncenterdental.com
1465 Route 31 South Suite 29 • Annandale, NJ 08801
(908)730-7565

Welcome to Clinton Center Dental

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: __________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______________ **SS#:** ___-__-____ **Prev. Visit:** ______________

Email Address: ____ **Best time to call:** ____________________

Phone: __________ __________ __________ _____ __________ __________
Home Mobile Work Ext Fax Other

Address: ______________________________ ______________________________
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

____

In an emergency, who should be notified? Please enter name, phone number and relationship below

____

____

Employer Name

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ____ **Phone:** ______________

Employer Address: ______________________________ ______________________________
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Do you have dental Insurance? If yes, please fill out the form below * ◯ Yes ◯ No

Primary Dental Insurance

Name of Insured: ____________________ ____________________ ____
Last First MI

Insured's Birth Date: ______________ **ID #:** ____________________ **Group #:** ______________

Insured's Address: ______________________________ ______________________________
Address 1 Address 2

____ ______ _____-____
City State Zip Code

Insured's Employer Name: ____________________

Employer Address: ____________________ ____________________

Address 1 Address 2

____________________ ______ _____-____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________________

Insurance Address: ____________________ ____________________

Address 1 Address 2

____________________ ______ _____-____

City State Zip Code

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

____

____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Medical History

Do you have any of the following medical conditions? If yes, please check all that apply. * ◯ Yes ◯ No

Please review each condition and check all that apply

☐ Allergy Doxycyline	☐ Allergy Latex	☐ Allergy Other	☐ Allergy Penicllin
☐ Alzheimers	☐ Anemia	☐ Arthritis	☐ Artificial Joint
☐ ArtificialHeartValve	☐ Asthma	☐ Back Problems	☐ Blood Disorder
☐ Cancer	☐ Chemical Dependency	☐ Chemotherapy	☐ Diabetes
☐ Dry Mouth	☐ Epilepsy / Seizures	☐ Fibromyalgia	☐ GERD
☐ Glaucoma	☐ HIV / AIDS	☐ Heart Disease	☐ Hepatitis
☐ Herpes	☐ High Blood Pressure	☐ Kidney Disease	☐ Liver Disease
☐ NeurologicalDisorder	☐ Nursing	☐ Osteoporosis	☐ Other:
☐ Pregnant	☐ Psychiatric Care	☐ Radiation Treatment	☐ RespiratoryCondition
☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Issues	☐ StomachProb/Ulcers
☐ Stroke	☐ TMJ / Jaw Pain	☐ Thyroid Condition	☐ Tuberculosis

Do you use any form of Tobacco or Nicotine containing products? * ◯ Yes ◯ No

Do you use any Controlled Substances (including Marijuana) for medicinal or recreational use? * ◯ Yes ◯ No

If any of the checked boxes need further explanation, please describe:

____

____

Do you take any medications (prescription or non-prescription)? If yes please list them below. * ◯ Yes ◯ No

Medications (list all):

____

____

List any Allergies (including drug, food, seasonal, etc.).

____

____

Preferred Pharmacy and Phone Number *

____

____

Dental History

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Please check if any of the following apply to you:

- ☐ Does it hurt to chew, bite, or swallow?
- ☐ Have you ever had periodontal (gum) treatment like scaling/root planing?
- ☐ Does your jaw click, pop, or hurt?
- ☐ Have you ever had an issue with dental anesthesia?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do you clench or grind your teeth?
- ☐ Does dental treatment make you nervous?

Have you experienced any of the following sleep-related breathing disorders?

☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

☐ Diagnosed Obstructive Sleep Apnea

Previous Dentist Name and Phone Number

____

____

Approximate date of most recent dental exam and/or dental x-rays

____

____

What is your immediate concern about your dental health?

____

____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Name of patient, parent, or guardian completing this form:

*

____

____

Relationship to patient: * ______________

Patient or Guardian Signature:

Signature ______________________________ **Date** ____________

Response Date: ____________