Riverdale Family Dental
CONFIDENTIAL
New Patient Forms

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____State: _____ Zip Code: _____

Reason for today's visit: _____

Check Appropriate Box:

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Cell Phone: _____ Home Phone: _____

Is it okay to text you? YES_____ ↔ NO_____

Email: _____

Emergency Contact Information:

Name: _____ Cell Phone: _____ Relation: _____

Whom may we thank for referring you?
_____

Insurance Information:

Are you the Primary Subscriber: ☐ YES ☐ NO
Subscriber Name: _____
Subscriber Birthdate: _____
Relationship to Subscriber: _____
Insurance Company: _____
Policy/ID Number: _____
Group Number: _____
Social Security Number: _____
Do you have a secondary insurance: _____

X_____ Date: _____
Patient, Parent or Guardian signature

Patient Medical History:

Physician's Name: _____
Office Phone: _____
Date of Last Exam: _____
Have you had any surgeries, serious illness, or hospitalization recently? ☐YES ☐NO
Please Describe (only if your answer was yes):

_____

	Yes	*No*
1. Do you use tobacco	☐	☐
2. Do you use alcohol, cocaine, or other drugs?	☐	☐
3. Are you wearing contact lenses?	☐	☐

_____

WOMEN ONLY	*Yes*	*No*
A. Are you pregnant or think you may be pregnant?	☐	☐
1. If you answered YES to the last question, how many months are you? _____		
B. Are you nursing?	☐	☐
C. Are you taking birth control pills?	☐	☐

_____

Allergies:
Please indicate if you are allergic to or have had any reactions to any drugs? Which of the following applies to you, check only if the answer is YES.

☐ Acetaminophen/Tylenol	☐ Acrylic	☐ Amoxicillin
☐ Aspirin	☐ Barbiturates	☐ Clindamycin
☐ Codeine	☐ Erythro	☐ General Anesthetics
☐ Ibuprofen/Motrin/Advil	☐ Iodine	☐ Latex
☐ Local Anesthetics	☐ Metal	☐ Novocain
☐ Penicillin	☐ Sedatives	☐ Sulfa

☐ No Allergies

Medical Conditions:

Please indicate which of the following applies to you, check all that applies.

☐ AIDS/HIV	☐ Alzheimer's	☐ Anaphylaxis
☐ Anemia	☐ Angina	☐ Anxiety
☐ Any Immune Deficiency	☐ Any Type of Implant	☐ Any Type of Transplant
☐ Arthritis	☐ Artificial Heart Valves	☐ Artificial Joints
☐ Asthma	☐ Back Problems	☐ Bad Breath
☐ Bleeding Gums	☐ Blood Disease	☐ Blood Transfusion
☐ Breathing Problems	☐ Bruise Easily	☐ Bulimia

☐ Cancer	☐ cardiovascular disease	☐ Chest Pain
☐ Circulatory Problems	☐ Clicking in Jaw	☐ Congenital Heart Disorder
☐ Convulsions	☐ Currently Nursing	☐ Currently Pregnant
☐ Depression	☐ Diabetes	☐ Difficulty in Chewing
☐ Difficulty in Opening Jaw	☐ Drug Addiction	☐ Earaches
☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting or Dizzy Spells
☐ Fingernail Biting	☐ Frequent Cough	☐ Frequent Diarrhea
☐ Frequent Headaches	☐ Frequently Tired	☐ G.E. Reflux/Persistent Heartburn
☐ Gastrointestinal Disease	☐ Genital Herpes	☐ Glaucoma
☐ Hay Fever	☐ Head/Neck Injury	☐ Headaches
☐ Heart Attack/Failure	☐ heart disease	☐ Heart Murmur
☐ Heart Rhythm Disorder	☐ Heart Surgery	☐ Heart Trouble
☐ Hemophilia	☐ Hepatitis	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Hives or Rash
☐ HPV	☐ Hypoglycemia	☐ Irregular Heartbeat
☐ Jaundice	☐ kidney disease	☐ Leukemia
☐ Lip or Cheek Biting	☐ Liver Disease	☐ Loose Teeth or Broken Fillings
☐ Low Blood Pressure	☐ lung disease	☐ Mitral Valve Prolapse
☐ Mouth Sores/Growths	☐ Neurological Disorders	☐ Osteopenia
☐ Osteoporosis	☐ Pacemaker	☐ Pain Around Ear
☐ Pain in Your Jaw (TMJ)	☐ Parathyroid Disease	☐ Periodontal Disease
☐ Recent Weight Loss	☐ Recurrent Infections	☐ Renal Dialysis
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Scarlet Fever	☐ Shingles	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Sleep Apnea	☐ Slow Healing Wounds
☐ Special Diet	☐ Spina Bifida	☐ Stomach Problems
☐ Stroke	☐ Swelling of Limbs	☐ Teeth Grinding/Clenching
☐ Thyroid Disease	☐ Tonsillitis	☐ Tooth Pain
☐ Tooth Sensitivity to Cold or Hot	☐ Tooth Sensitivity to Sour	☐ Tooth Sensitivity to Sweets
☐ Tooth Sensitivity when Biting	☐ Tuberculosis (TB)	☐ Tumors or Growths

☐ Ulcers	☐ Use of Controlled Substances	☐ Use of Tobacco Products
☐ Venereal Disease	☐ Wearing Contact Lenses	☐ Other_____ _____

☐ No Medical Condition's

Medical Treatment:

Please indicate which of the following applies to you, check all that applies.

☐ Chemotherapy	☐ Psychiatric Treatment	☐ Radiation Treatment

☐ Not Receiving Any Treatments

Medication:

Please indicate which of the following applies to you, check all that applies. If none apply, select "No Medications" or write the names of your medications underneath "Other medications".

☐ Any Bisphosphonates	☐ Actonel	☐ Boniva
☐ Cortisone Medicine	☐ Fosamax	☐ Oral Contraceptives

☐ Other Medications:

_____

_____

_____

_____

☐ No Medications

X_____ Date: _____

Patient, Parent or Guardian signature

Financial Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

Patients: Adult patients are responsible for full payment at the time of service. The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Regarding Payment:

- We accept the following forms of payment, *Cash, Check, Credit Card,* and *Care Credit*.

Payment for services is due at the time of services are rendered. All previous balances must be paid before continuing with dental care.

- If dentures, partial dentures, crown, and bridge are to be fabricated by a dental laboratory a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

Deductible/ Co-Payments: We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card.

Delinquent Payments: It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee. Any returned checks are subject to a $35 fee. All payments that are not made within 30 days of service or 30 days of receiving statements will incur a 5% late fee on their account. If after 60 days, the account is not satisfied it will be sent to a Third-Party collection agency and a$35 processing fee will be placed on the account.

Missed Appointments: Unless cancelled in advance, all patients *MUST* give a 24-hour notice for any cancelled or rescheduled appointments. If less time is given or appointments are missed completely a $35 fee will be billed. After *THREE* missed appointments without prior notice, we have the authority to dismiss you as a patient of this office. Please help us service you better by keeping scheduled appointments.

Regarding Insurance: We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount within 60 days, the balance will be transferred to your account, and you will be responsible for payment. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment will be expected immediately. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary fee for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Benefits must be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service. We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

By selecting Accept, I confirm that I have read, understand, and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. Please let us know if you have any questions or concerns.

X_____ **Date:** _____

Patient, Parent or Guardian Signature

Notice of Privacy Practices

The privacy of your health is important to us

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of about our privacy practices, our legal duties, and our rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 01/01/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information that we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare 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 credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health Information to notify, assist, in the notification of (including identifying or locating) a family member, your person representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick filled prescriptions, medical supplies, x-rays, or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health and safety, or to the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient care under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messaging or letters).

<u>PATIENT RIGHTS</u>

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a responsible cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information, and postage if you want the copies mailed to you. Radiographs (X-rays) will be duplicated at a reasonable fee. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or

an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our free structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notes: If you receive this Notice on a Website or by electronic mail (Email or Text messaging service), you are entitled to receive this Notice in Written Form.

Riverdale Family Dental, PA
At Riverdale South

51 Route 23 South, Riverdale, NJ 07457
973-831-2901

Dr. Sookie Hwang DDS

Riverdale Family Dental

Acknowledgement of Receipt Notice of Privacy Practices

You may refuse to sign this Acknowledgement.

I _____, have received a copy of this office's Notice of Privacy Practices.

Please Print:

_____

Signature:

_____

Date:

_____

<u>For Office Use Only</u>

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ **The individual refused to sign.**
- ☐ **Communication barriers prohibited obtaining the acknowledgement.**
- ☐ **An emergency prevented us from obtaining acknowledgement.**