ORLANDO FAMILY DENTISTRY, LLC

312 Route 31 North
Hopewell, NJ 08525
(609) 466-1332
www.orlandofamilydentistry.com

NEW PATIENT FORM AND REGISTRATION

Today's Date:

Title:	First Name (LEGAL)		Middle Name:	Last Name:	I prefer to be called:
Gender	Date of Birth	Age	Marital Status:	EMAIL Address @yahoo @gmail @comcast @_____	Driver's License State & #:
Social Security #		Primary Phone Land Mobile		Secondary Phone	Work Phone
Home Address:		City:		State:	Zip Code
Are you Employed? YES NO		Employer's Name:		Employer's Phone:	Occupation:
If 18 or over - Do we have permission to speak to your parent about your treatment? YES NO				Are you a Student? YES NO	School Name
Send appointment Reminders via: (circle all that apply) TEXT EMAIL CALL ONLY					
Do we have permission to leave messages on a voicemail? YES NO					Please circle any that apply: MOBILE HOME WORK
Please tell us where you heard about us (**circle ALL that apply**) *Friend or relative (Name_____)* *Saw our office (Location)* *Doctor* *Search Engine (Google, Yahoo, Bing)* *Insurance Company* *Website*					
Was our website a factor in your decision to visit our practice? YES NO					
Name of Spouse (or Parent, if a minor)		Spouse/Parent's Employer:			Spouse/Parent Cell Phone:

EMERGENCY CONTACT — This should be the nearest relative who does not live with the patient

Name:	Relationship to Patient	Phone Number:
Do we have permission to contact this person? YES NO		

PERSON RESPONSIBLE FOR FINANCES

Name (If Self, skip)	Address:	State	Zip
Primary Phone Land Mobile	Secondary Phone Land Mobile	Work Phone	Relationship to Patient
Primary Email	Secondary Email		Employer's Name

PRIMARY DENTAL INSURANCE

Insured's Name:	Insured's Date of Birth	Insured's ID # or SS#	Relationship to Patient
Insured's Employer:	Insurance Company	Group #	Do you have a card YES NO

SECONDARY DENTAL INSURANCE

Insured's Name:	Insured's Date of Birth	Insured's ID # or SS#	Relationship to Patient
Insured's Employer:	Insurance Company	Group #	Do you have a card YES NO

AUTHORIZATION FOR PAYMENT

All of the above information is correct to the best of my knowledge. I authorize use of this form on all of my insurance submissions and I authorize the release of information to all of my insurance companies. I understand that I am responsible for my bill. I authorize Orlando Family Dentistry, LLC to act as my agent in helping me to obtain payment from my insurance company (ies). I authorize payment to Orlando Family Dentistry, LLC. I permit a copy of this authorization to be used in place of the original. I give Orlando Family Dentistry, LLC, its employees and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance or payment.

I understand that this office accepts assignment of insurance benefits, with the understanding that any portion not covered by my insurance company will be my responsibility. I am aware that any insurance estimates given to me were not a guarantee of payment or eligibility with my provided insurance. I understand that my dental insurance is a contract between me, the Insured Member, the Insured's Employer and the Insurance company. Depending on my specific insurance plan my dental insurance may not fully cover the fees that this office charges. I am ultimately responsible for all services and payments.

I have read, understood and agree to the above authorization of payment

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

CONSENT FOR TREATMENT and OFFICE POLICY

Patient Name (Please Print):

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon diagnosis, I authorize the doctor or designated staff to perform recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Returned Checks	Personal Checks that are returned due to "insufficient funds" are subject to a $35.00 service fee
Service Charge	Payment is due at each appointment. I agree to pay any outstanding bill regardless of insurance within 60 days. If I do not pay the entire balance within 60 days of the monthly billing date, a service charge will be added to the account of the current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the unpaid balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts.
Minors or Elderly	Adult patients are responsible for full payment at time of service. The adult accompanying the minor/elder is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor/elder. For unaccompanied minors/Elders, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Missed or Cancelled Appointments Our Team of professionals have set aside a specific amount of time for your appointment. Every attempt is made to honor that time, barring emergencies. If you are unable to keep your appointment, please notify our office immediately (if possible at least 24 hours in advance). This will allow sufficient time to offer another patient this time slot. Recurring missed appointments are subject to a BROKEN APPOINTMENT FEE of $50-$150/ per appointment.

I have read, understood and agree to the above consentment of treatment and Office policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

MEDICAL AND DENTAL HISTORY **Check YES OR NO that apply**

Yes	No	
☐	☐	Abnormal Bleeding/Hemophilia
☐	☐	Abuse-Drug/Alcohol/Narcotic
☐	☐	Alzheimer's Disease/Dementia
☐	☐	Anemia
☐	☐	Angina/Chest Pain
☐	☐	Arthritis
☐	☐	Artificial Bone/Joint ***
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer Type_____
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Defect
☐	☐	Diabetes Type_____
☐	☐	Difficulty Breathing/Emphysema
☐	☐	Dizziness/Fainting Spells
☐	☐	Epilepsy/Seizures
☐	☐	Frequent Headache/Migraine
☐	☐	Glaucoma
☐	☐	Heart Attack/Surgery- Year_____
☐	☐	Heart Murmur
☐	☐	Hepatitis A B C
☐	☐	Herpes/Fever Blisters/Cold Sores
☐	☐	High Blood Pressure/Hypertension
☐	☐	HIV+/AIDS
☐	☐	Hives/Skin Rash
☐	☐	Intestinal/Colitis/Chrones
☐	☐	Irregular Heartbeat
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Mitral Valve Prolapse***
☐	☐	Numbness or Tingling
☐	☐	Osteoporosis
☐	☐	Pacemaker
☐	☐	Psychiatric Problems
☐	☐	Radiation
☐	☐	Rheumatic/Scarlet Fever
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Swollen/Painful joints or Neck
☐	☐	Tattoos/body piercing
☐	☐	Thyroid
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease/STI
☐	☐	Weight Loss

ALLERGIES - Have you ever had ann adverse reaction or allergies to any medication or substance

Yes	No	
☐	☐	Acrylic
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics _____
☐	☐	Erythromycin
☐	☐	Iodine
☐	☐	Latex Rubber
☐	☐	Metals _____
☐	☐	Nitrous Oxide
☐	☐	Penicillin/Antibiotics
☐	☐	Sedatives
☐	☐	Sulfa Drugs
☐	☐	Tetracycline
☐	☐	Valium/Xanax
☐	☐	Xylocaine
☐	☐	Any not listed:_____

LIST ALL MEDICATIONS CURRENTLY TAKING & DOSE:

_____

_____

_____

_____

_____

Do you Require PREMEDICATION Antibiotics for Dental Treatment? **YES** **NO**

If Yes, What do you premed with _____

Dental History

Previous Dentist Name/Location _____

Approximate Last Visit _____

Reason For Leaving _____

Are you a Smoker YES NO How Long _____

History of Pain in Jaw Joints(TMD/TMJ): YES NO

Do you Bite your Nails or Chew/Suck on Candy? YES NO

Do you sip coffee/soda all day? YES NO

Has fear ever been an issue for you? YES NO

What would you like us to address with you

PAIN/ACHE DENTAL HYGIENE BAD BREATH

IMPLANTS TOOTH REPLACEMENT GUM ISSUE

APPEARANCE OF TEETH/COLOR/SHAPE/POSITION

How often do you Brush? _____ Day Week

How often do you Floss?_____ Day Week

All of the previous information is correct to the best of my knowledge. 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. I may be asked to update my medical history upon each return visit. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you may have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):		Date (mm/dd/yyyy):
Physician's Name and Location:	Phone Number:	Last Visit:

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information. We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare of with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use and disclosure. If you are not present, or in the event of your incapacity or an emergency we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment at our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations apply to us; some may never come up at our office at all. Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for specific purpose.

For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices

Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
Uses or disclosures for health-related research
Uses and disclosures to prevent a serious threat to health or safety
Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of the members of the foreign service
Disclosures of de-identified information
Disclosures relating to worker's compensation programs
Disclosures of a "limited data set" for research, public health, or healthcare operations
Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
Disclosures to "business associations" whom perform healthcare operations four our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
The right to inspect and copy your protected health information.
The right to receive and accounting of disclosures of protected health information.
The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of April 23, 2013, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.
We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services. Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and/or to file a complaint, please call or visit:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing the consent, I authorize Orlando Family Dentistry, LLC to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time ant that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke, this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
If signing on behalf of someone, explain your relationship to the patient:	

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt

The following circumstances prohibited the patient from signing the consent form:

Describe your good faith effort to obtain the individual's signature on this form:

Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date (mm/dd/yyyy):