WELCOME TO OUR OFFICE

We're glad you have chosen us for your dental care. So that we may provide you with the best possible care please complete all **4 Pages** of this Medical/Dental history/Oral Cancer Screening/ Patient information.

HEALTH QUESTIONNAIRE

NAME ______________________________ BIRTH DATE______________

DENTAL HISTORY

1. Reason for present visit ______________________________
2. Date of last dental visit______________What was done on that visit?______________
3. How often do you have dental exams?______________________________
4. Does dental treatment make you nervous? ___yes ___no
5. Have you ever had serious trouble associated with previous dental treatment? ___yes ___no
   Explain______________________________

6 Are you interested in **Sedation** for your dental appointment? ___ yes ___ no (using pills to relax you)
7. Are you interested in **Sleep Dentistry** for your dental appointment? ___ yes ___ no (I.V. Sedation by our anesthesiologist)
8. Are you on pain now? ___yes ___no If yes, explain______________________________
9. Is it important for you to keep your teeth for a lifetime? Y N Explain______________________________
10. What do you use on a daily basis to clean your mouth? ___brush ___floss ___other______________
11. Do you clean your tongue? ___yes ___no If yes, How______________________________
12. Many patients consult with us for another opinion. Have you seen another Dentist for your needs? ___yes ___no___
    If yes, explain______________________________

Do you have/have you had any of the following problems....

	YES	NO	WHERE		YES	NO	WHERE
Bleeding, sore gums	___	___	___	Loose teeth	___	___	___
Burning lips/tongue	___	___		Sensitivity to hot	___	___	___
Frequent blisters lips/mouth	___	___		Sensitivity to cold	___	___	___
Cheek biting	___	___		Sensitivity to sweet	___	___	___
Difficulty opening or closing	___	___		Hurts when chewing	___	___	___
Pain in the jaw/ears	___	___	___	Areas of food impaction	___	___	___
Have your teeth moved	___	___		Grinding your teeth	___	___	When?___
Ringing in the ear	___	___		Sore teeth	___	___	___
Locked open or closed	___	___		Broken teeth	___	___	___
Clicking/popping in the jaw	___	___	if **YES,** do you still have it or did it go away				___
Frequent headache	___	___		Are you often fatigued	___	___	
Facial pain	___	___		Restless Leg Syndrome	___	___	
Muscle pain-head or neck	___	___		Trouble Sleeping	___	___	
Bad breath	___	___		Wake gasping for air	___	___	(or has anyone observed?)
Bad taste in your mouth	___	___		Tonsils/Adenoids removed	___	___	
Snoring	___	___		Allergies	___	___	
Congestion/Sinus infection	___	___		Frequent Nightmares	___	___	
History of facial trauma/car accident/fall/whiplash?	Y	N		Mouth Breathe while sleeping	___	___	

Explain: ______________________________

Have you ever been treated for...

	Y	N	Describe	
Orthodontics (braces)	___	___	___	How long? ____ years
Periodontal Disease (gum disease)	___	___	___	
TMJ (jaw problems)	___	___	___	
Bad bite (had bite adjusted)	___	___	___	

APPEARANCE

1. Are you happy with the appearance of your front teeth? ___yes ___no explain___________________________
2. Would you like your teeth ___ longer ___ straighter ___ more even ___ close spaces ___ to stay the same
3. Do you desire whiter teeth? ___yes ___no
4. Are you interested in bleaching your teeth? ___yes ___ no ___ Home bleach ___ Zoom ___ Deep Bleach
5. Do you desire tooth colored fillings? ___yes ___no
6. Are you missing teeth that you want replaced? ___yes ___no Where?___________________________
7. If you had a magic wand and could change anything about the appearance of your smile what would you like to do?___________________________
8. Do you actively engage in any sports activities? ___yes ___no What? ___________________________
9. What type of dentistry is most important to you ___ Most economical ___ Highest quality

MEDICAL

1. My last physical was on__________ Results of your last physical___________________________
   a. Name, address and phone # of physician___________________________
   b. Are you being treated by your physician for any disorder? ___yes ___no What?___________________________

DO YOU HAVE /HAVE YOU HAD	yes	no		yes	no
Heart disease (heart attack, angina)	___	___	Kidney disease	___	___
High blood pressure	___	___	Arthritis	___	___
Heart murmur	___	___	Digestive disorders/GERD	___	___
Rheumatic fever/heart disease	___	___	Venereal disease	___	___
Diabetes	___	___	AIDS/HIV positive	___	___
Asthma	___	___	Hepatitis	___	___
Replacement joints	___	___	Seizures/Epilepsy	___	___
Pacemaker	___	___	Blood transfusion	___	___
Glaucoma	___	___	Cancer Where__________	___	___
Tuberculosis	___	___	A cough that produces blood?	___	___
High cholesterol	___	___	Osteoporosis	___	___
Have you had Bacterial endocarditis?	___	___	Do you have a prosthetic heart valve?	___	___
Have you had a heart transplant?	___	___	Do you have congenital heart disease?		
Do you have a stent? Placed________	___	___	(excluding Mitral Valve Prolapse)	___	___
Have you taken any Biphosphonate drugs (Actenol, Fosamax, etc.) in the last 10 years?				___	___

Have you ever had any psychiatric care **Y N** explain: ___________________________

ARE YOU TAKING ANY MEDICATION? ___Yes ___No (please include all herbal and over-the-counter)

List ALL with dosage and frequency: Prescribed___________________________

____

Over the counter medication:___________________________

Have you ever been hospitalized? Y N Describe ___________________________

MEDICATIONS NOT TOLERATED

List:___________________________

ARE YOU ALLERGIC TO ANY MEDICATION? ___YES ___NO

List:___________________________

Do you require premedication for your dental visits?___yes ___no Do you take aspirin daily? ___yes ___no

Have you had abnormal bleeding associated with previous extractions, surgery? ___yes ___no

Do you smoke?___yes ___no Amount___________ Do you drink alcohol? ___yes ___no Amount___________

WOMEN Are you pregnant? ___yes ___no Any chance pregnant? ___yes ___ no Are you taking birth control? ___yes ___no
Are you planning to pregnancy in the near future? ___ yes ___ no

ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT I SHOULD KNOW ABOUT?

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or medication at any time, I will inform Dr. Goldstein at my next appointment.

___________________________ ___________________________

SIGNATURE OF PATIENT DATE SIGNATURE OF DOCTOR DATE

PATIENT INFORMATION

DATE__________

Name:____________________ Home Phone#____________ Cell#____________ ❑ single ❑male ❑married ❑female❑ minor

Address:____________________________________ E Mail ______________________
STREET APT# CITY STATE ZIP

Birthdate:___/___/___ SS#__________________ Drivers lic#______________________

Employer_________________________________ Work Phone #____________________

Address____
STREET CITY STATE ZIP

May we call you at work to confirm an appointment ____ yes ___no

Has any member of your family been treated in our office? ❑ yes ❑ no

Whom may we thank for referring you to our office?__________________________________

Most convenient appointment time____________________________________

How do you prefer to be addressed? _____________________________________

FAMILY INFORMATION

Spouse Name_________________________ Birthdate____/____/____ SS#______________
if a minor parent or guardian

Address____
STREET APT# CITY STATE ZIP

Employer___________________________ Home Phone#________________________

Address____________________________________ Work Phone#______________
STREET CITY STATE ZIP

PERSON RESPONSIBLE FOR ACCOUNT

Check one ❑patient ❑ father or husband ❑guardian ❑ mother or wife

PERSON TO CONTACT IN CASE OF EMERGENCY Name___________________________ Phone #______________

Address____

METHOD OF PAYMENT

PLEASE CHECK THE METHOD OF PAYMENT FOR YOUR FIRST VISIT.

❑ CASH ❑ CHECK ❑ MC ❑ VISA ❑ AMEX ❑ DISCOVER

AUTHORIZATION

TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT, I AUTHORIZE DISCLOSURE OF THE PATIENT'S RECORD AND ANY INFORMATION NECESSARY. A PHOTOCOPY OF THIS AUTHORIZATION IS CONSIDERED TO BE VALID AS AN ORIGINAL.THE INFORMATION ON THIS PAGE AND THE MEDICAL HISTORY ARE CORRECT TO THE BEST OF MY KNOWLEDGE. IN ADDITION, PHOTOS AND X-RAYS MAY BE TAKEN OF ME BEFORE, DURING AND AFTER TREATMENT AND I CONSENT TO THEIR RELEASE. I UNDERSTAND THAT SOME OF THIS INFORMATION MAY BE USED IN AN ACADEMIC SETTING AND EVERY EFFORT WILL BE MADE TO CONCEAL MY IDENTITY. ALL ACCOUNTS OVER 30 DAYS WILL INCUR INTEREST OF 1.5% PER MONTH OR 18% ANNUALLY. IN ADDITION, PATIENT WILL BE RESPONSIBLE FOR ALL LEGAL COSTS OF COLLECTION SHOULD THEIR ACCOUNT BECOME OVERDUE. YOU AGREE TO REIMBURSE US THE FEES OF ANY COLLECTIONS, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 33% OF THE DEBT, AND ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES WE INCUR IN SUCH COLLECTION EFFORTS.

Our Privacy Notice:

We are committed to maintaining the confidentiality, integrity and security of personal information entrusted to us by current and prospective patients. We want you to know how we protect your information and how we use it to service you. You entrust us with personal information and we take that trust very seriously. We do not share any nonpublic personal information about you with any third parties except as necessary to assist you with your insurance needs, or to coordinate and sequence your treatment with other specialists. We restrict access to your personal information to those employees who need to know this information to provide the highest level of care and treatment for you. In addition, we maintain physical and procedural safeguards to protect your personal information.

PATIENT SIGNATURE__________________________________ DATE____________

RESPONSIBLE PARTY__________________________________ DATE____________

Statement of Financial Policy

Please fill out form completely prior to seeing the Doctor

At Randolph Dental Care, we believe that you deserve the best care. That is why we always present you with the best possible dental solution in treating your personal situation. Each year we provide outstanding dental care to thousands of patients. Some have dental benefits and some do not. Whether you have dental insurance or not.... **Payment Is Due at the Conclusion of Each Office Visit. If You Have Dental Benefits, You Will Be Responsible For Your Co-pay For That Day.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). We currently participate with Delta Dental Premier only. This means that we work with literally thousands of companies. Although we maintain a computerized database of insurance information, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is only an **Estimate**. The amount that your plan pays is determined by how much your employer pays for the plan. The less paid for the plan, the less coverage you will receive. If you have any questions regarding the details of your insurance plan, we suggest you read your employee benefit manual, call your insurance carrier and/or contact your employer/human resources department regarding the dental plan which they are providing to you.

We bill your insurance as a courtesy. However, the responsibility for full payment of your account rests with you regardless of your insurance status. **If insurance does not pay within 45 days, Randolph Dental Care reserves the right to request payment in full for services from you and let you collect the insurance funds that are due you.** This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU** and your insurance company. Our office is not, and can not, be part of that legal contract. **Randolph Dental Care does require payment in full for your portion at the time of service. Please note: if any services are required to be billed through your medical carrier we will request payment from you and you will seek reimbursement from your carrier.**

PAYMENT OF ALL UNPAID INSURANCE BALANCES

On your last day of treatment a final insurance claim will be submitted to your insurance company. **After payment is received any Unpaid Insurance Balance Is the Responsibility of the Patient.**

Please indicate method of payment:

____ I would like any unpaid insurance balance to be placed on my credit card

Credit Card Number ________________________ Expiration Date ____________ SEC#________

[This authorization will remain in effect until revoked by me in writing]

____ I would like to be billed for any unpaid insurance balance (Due net 10 days).

If you are interested in obtaining credit for your dental treatment please speak to our office manager about financing through Care Credit or Lending Club Payment Plans.

There is a charge of 1.5% added each month to accounts unpaid after 30 days. After 60 days, collection action will be taken on all delinquent accounts and all legal fees and costs of collection will be incurred by the account holder.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics, Medicare and managed care facilities with severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."** As your dental health care provider, it is our responsibility to provide accurate diagnosis and exceptional treatment. That is our first priority. Your diagnosis and treatment will be provided according to your needs – not according to the policy of an insurance company. The service to our patients is anything but "usual and customary".

****

On your first visit we will take 2 sets of X-rays- a Full Mouth Series and a Panorex, each for very different reasons. It is important for you to know your insurance will cover the first set. The Full mouth series is for detailed analysis of your teeth. The Panoramic X-ray is used to evaluate your TM joint, Sinuses, 3rd molars, Carotid arteries for plaque build up and to screen for Cancer. The cost of the Panorex is $150. Please let us know if you would prefer to have the second set done.

___ **I CHOOSE** to have the Panoramic X-ray taken
___ **I DECLINE** the Panoramic X-ray

A Word About Missed Appointments

The nature of our practice is to give our patients the utmost in dental care and service in a professional environment. In fairness to others and to enable us to efficiently plan the day's schedule, it is necessary that you give us sufficient prior notification if you need to reschedule your dedicated appointment time. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. **If you must change your appointment, we require at least 24 hours notice for all appointments scheduled up to one hour. All appointments that are more than one (1) hour require 48 hours notice. Please keep this in mind should you need to cancel an appointment in order to avoid a $100.00 per hour broken appointment fee.**

We thank you for helping our office run as smoothly and efficiently as possible for all patients, welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted.

I have read, understand and accept both the Financial Policy and Broken Appointment Fee Policy.

Signature ___________________________________ Date _____________
Print Name __________________________________

Randolph Dental Care- Glen M Goldstein DMD DICOI

Oral Cancer Screening Consent Form

We are very concerned about oral cancer, and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that in 2007, they expect a remarkable 11% increase in this deadly disease. **Alarmingly, 25 % of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age and tobacco and alcohol use.**

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The **VELscope** (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope hand piece and the dentist may find tissue abnormalities at an earlier stage. Before the exam, the room is darkened and much like "dessert storm night vision technology" the clinician can see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurances. The fee for this enhanced examination is $ 30. As part of our standard or care and because we care about you, we strongly recommend that you choose this additional screening procedure. In the future we will perform this exam at all cleaning/check up appointments.

Please sign the area below to accept the financial responsibility for this procedure.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

____YES -I authorize the office to perform the VELscope examination.

_____NO- I wish to pass on this examination.

Print Name____

Signature____ Date _____________

Randolph Dental Care
1243 Sussex Turnpike
Randolph, NJ 07869
973-895-7995

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 IT CAREFULLY.

PLEASE REVIEW IT CAREFULLY.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic dental record
- Correct your paper or electronic dental record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Share your information with specialists

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you a dental problem asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from dental or health plans or other entities.

Example: We give information about you to your dental insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice 09/23/2013
- The privacy official in our office is Suzanne who can be reached at 973-895-7995 or at Randolphdental@att.net
- We never market or sell personal information.

Patient Name____

Signature ____ Date _______________