

WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____

Date of Last X-Rays _____

City, State _____

How Often Do You Floss? _____

Date of Last Dental Visit _____

How Often Do You Brush? _____

Please check all that apply:

- | | | |
|--|--|---|
| Bad Breath..... <input type="checkbox"/> | Loose Teeth or Broken Fillings..... <input type="checkbox"/> | Sensitivity to Sweets <input type="checkbox"/> |
| Bleeding Gums <input type="checkbox"/> | Orthodontic Treatment <input type="checkbox"/> | Sensitivity When Biting <input type="checkbox"/> |
| Blisters on Lips or Mouth <input type="checkbox"/> | Pain Around Ear <input type="checkbox"/> | Frequent Headaches <input type="checkbox"/> |
| Finger Nail Biting <input type="checkbox"/> | Periodontal Treatment <input type="checkbox"/> | Jaw, Head or Neck Injuries <input type="checkbox"/> |
| Grinding Teeth <input type="checkbox"/> | Sensitivity to Cold <input type="checkbox"/> | Jaw Difficulty: Clicking and/or Pain.. <input type="checkbox"/> |
| Lip or Cheek Biting <input type="checkbox"/> | Sensitivity to Heat <input type="checkbox"/> | Tooth Pain <input type="checkbox"/> |

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? Yes No

2. Have you ever had any serious illnesses or operations? Yes No

3. Are you currently taking any medication? Yes No

Please describe: _____

4. Do you smoke? Yes No

5. Do you use alcohol, cocaine or other drugs? Yes No

6. Do you wear contact lenses? Yes No

7. Have you had any allergic reactions to the following:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

8. (Women Only) Are You:

- | | Yes | No |
|-----------------------------------|--------------------------|--------------------------|
| Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

- | | | | | | |
|---|--------------------------|-----------------------------|--------------------------|-----------------------------------|--------------------------|
| AIDS | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | Pacemaker..... | <input type="checkbox"/> |
| Anemia..... | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> |
| Arthritis, Rheumatism | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | Radiation Treatment..... | <input type="checkbox"/> |
| Artificial Heart Valves | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Respiratory Disease..... | <input type="checkbox"/> |
| Artificial Joints | <input type="checkbox"/> | Headaches..... | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> |
| Back Problems | <input type="checkbox"/> | Heart Problems..... | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| Bleeding abnormally,
with extractions or surgery | <input type="checkbox"/> | Hepatitis-Type | <input type="checkbox"/> | Sinus Trouble..... | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | Herpes..... | <input type="checkbox"/> | Skin Rash | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Chemical Dependency | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | Swelling of Feet/Ankles..... | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | Swollen Neck Glands..... | <input type="checkbox"/> |
| Chronic Fatigue Syndrome | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | Thyroid Problems..... | <input type="checkbox"/> |
| Circulatory Problems | <input type="checkbox"/> | Latex Sensitivity | <input type="checkbox"/> | Tonsillitis | <input type="checkbox"/> |
| Congenital Heart Lesions..... | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> |
| Cortisone Treatments | <input type="checkbox"/> | Liver Disease..... | <input type="checkbox"/> | Tumor or growth on head/neck..... | <input type="checkbox"/> |
| Cough - persistent or bloody..... | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | Ulcer..... | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | Mitral Valve Prolapse..... | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| | | Nervous Problems..... | <input type="checkbox"/> | | |

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

**John A. Williams Jr. DMD
1457 Raritan Road Ste. 101
Clark, NJ 07066**

To My Valued Patient,

This year marks the beginning of many exciting changes in my office in my effort to improve service and quality of care for you, so that you can regain and maintain your health as quickly, efficiently, and inexpensively as possible.

I have a mission – and that is to get our patients healthy and to prevent any dental problems from occurring in the future. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you. If you cannot keep your appointments and adhere to my treatment recommendations, I will not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. **Cleanliness and infection control are of the utmost importance.** We have the latest sterilization technology and disinfect each treatment room after every patient. This is an important reason we demand timeliness of ourselves and you.
2. **Timeliness is required.** We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.
3. **No-shows are not acceptable.** Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 24 hours of your appointment to reschedule. There is a \$50.00 fee for all no-show appointments and this fee is not covered by insurance.
4. **If you miss an appointment** we strongly recommend that you re-schedule your appointment as soon as possible. It is important to your dental health to do so to avoid setbacks in the care and maintenance of your teeth and gums.
5. **Insurance:** Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being – we are. We will provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We can not be responsible for what your insurance will or will not cover.
6. **We run a Zero Balance office,** therefore all financial aspects of your treatment will be discussed prior to the beginning of treatment. Any and all co-payments must be made at the time treatment is rendered. All patients are expected to comply with their financial agreement with this office. Any insurance balance not received after 90 days will become your responsibility.
7. **Upsets.** It is our office policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you should an upset occur provided you bring it to our attention in an appropriate, cordial manner at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that my staff will treat you with the same professional demeanor and efficiency as you would expect from them. Please see Debbie our office manager to resolve immediately any upsets you may have with my office or one of my team.

I greatly appreciate your cooperation.

Yours in Health,

Dr. John A. Williams Jr.

Patient

Office Manager

John A. Williams Jr. DMD

ACKNOWLEDGEMENT OF RECEIPT OF 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 Name}

{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 acknowledgement
- Other (Please Specify)

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John A. Williams Jr. DMD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION 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 about our privacy practices, our legal duties, and your 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 (01/01/2006), 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 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 this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

Payment: We may use and disclose your health information to obtain payment for services we provide 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 credentialing 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 to 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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 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, or assist in the notification of (including identifying or locating) a family member, your personal 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 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 up filled prescriptions, medical supplies, x-rays, or other 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 use or 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 or safety or the health or 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

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 practicably 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 reasonable 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 will charge you \$25.00 to locate and copy your health information, and postage if you want the copies mailed to you. 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 fee 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 Communication: 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 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 Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Contact Officer: John Williams

Telephone: 908-276-4567

Fax: 908-272-5172

E-mail: _____

Address: 1457 Raritan Road Clark, NJ 07066 _____

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