

Date: _____

DENTAL CHARM LLC

116 Millburn Ave. #109 Millburn, NJ 07041

dentalcharmllc@gmail.com

Tel: 973-921-9098

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name: _____ Soc. Sec. #: _____
Last Name First Name Initial

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Sex: F M Age: _____ Birthdate: _____ Status: Single Married Widowed Separated Divorced

Phone Number: _____

Email Address: _____

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Primary Insurance

Person Responsible for Account:

Last Name First Name Initial

Relation To Patient: _____ Birthdate: _____ Soc. Sec. #: _____

Address (If different from patient's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Person Responsible Employed By: _____ Occupation: _____

Insurance Company: _____

Subscriber/Member ID#: _____ Group #: _____ Contract #: _____

Additional Insurance

Is Patient covered by additional Insurance? Yes No

Subscriber Name: _____ Relation to Patient: _____ Birthdate: _____

Address (If different from patient's) _____ City: _____

State: _____ Zip: _____ Phone: _____

Insurance Company: _____

Subscriber/Member ID#: _____ Group #: _____ Contract #: _____

Subscriber Employed by: _____

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Dental History

Reason for Today's Visit: _____ Date of Last Dental Care: _____

Former Dentist: _____ Date of Last Dental X-Rays: _____

Address: _____

Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Sensitivity to Hot
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Loose Teeth or Broken Fillings	<input type="checkbox"/> Sensitivity to Sweets
<input type="checkbox"/> Clicking or Popping Jaw	<input type="checkbox"/> Periodontal Treatment	<input type="checkbox"/> Sensitivity when Biting
<input type="checkbox"/> Food Collection Between Teeth	<input type="checkbox"/> Sensitivity to Cold	<input type="checkbox"/> Sores or Growths in your Mouth

How often do you floss? _____ How often do you Brush? _____

Medical History

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? _____ If yes, describe: _____

Have you ever had any complications following dental treatment? _____ If yes, describe: _____

Do you have any health problems that need further clarification? _____ If yes, describe: _____

(Women) Are you currently pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

Check (✓) if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough Up Blood	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Skin Problems/Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tobacco habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Headaches	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease

MEDICATIONS

List medications you are currently taking:

ALLERGIES

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change to my health, I will inform my doctors at the next appointment without fail.

X _____ Date _____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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 charge whether or not paid by insurance.

X _____ Date _____

DENTAL CHARM LLC FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS: Unless we receive notice of cancellation at least 24 hours in advance, you will be charged \$50.00 Please help us service you better by keeping scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware that some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

Please indicate below the form of payment you wish to choose.

- () Cash or check
- () Visa, MasterCard, Discover
- () If you qualify, a monthly payment plan is available for your convenience.

If payment is delinquent, the patient will be responsible for payment of collection.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature: _____

Date: _____