Date: _____

Patient Information

Patient's Name: _____ DOB: _____
Last Name First Name

Nickname: _____ Gender: _____ Pronouns: _____ Marital Status: _____

Social Security #: _____-_____-_____ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home: _____ Work: _____ Ext. _____

Cell: _____ Best Time to Call: _____

Referral Information

How did you hear about us? _____

Spouse or Responsible Party Information (If Different from above)

Name: _____ DOB: _____
Last Name First Name

Gender Identity: _____ Pronouns: _____ Social Security #: _____-_____-_____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home: _____ Cell: _____

Medical Insurance Information

Primary

Name of Insured: _____ Relationship to Insured: _____
Last Name First Name

Name of Employer: _____

Insured's Birth Date: _____ID #: _____Group #: _____

Insurance Company: _____

Insurance Co. Phone #: _____ Do you have secondary coverage? _____

Secondary

Name of Insured: _____ Relationship to Insured: _____
Last Name First Name

Name of Employer: _____

Insured's Birth Date: _____ID #: _____Group #: _____

Insurance Company: _____

Insurance Co. Phone #: _____

In Case of Emergency Contact

Name of Contact: _____
Last Name First Name

Patient's Relationship to Contact: _____ Best Phone # to reach: _____

Reverse Side →

Medical/Dental History (Check the boxes that apply)

☐ Artificial Heart Valve	☐ Hepatitis A, B, C, D, E	☐ Oral Herpes
☐ Artificial Joints	☐ AIDS/HIV	☐ Chemical Dependency
☐ Pacemaker/Defibrillator	☐ Sleep Apnea	☐ Jaundice/Liver Disease
☐ Organ Transplant	☐ Headaches	☐ Ulcer
☐ High Blood Pressure	☐ Sinus Problems	☐ Immunosuppressive
☐ Low Blood Pressure	☐ Back Problems	☐ Blood Thinners
☐ Heart Problems	☐ Hemophilia	☐ Circulatory Problems
☐ Heart Murmur	☐ Diabetes	☐ Breathing Problems
☐ Stroke	☐ Thyroid Disease	☐ Asthma
☐ Psychiatric Care	☐ Cancer/Leukemia	☐ Respiratory Disease
☐ Epilepsy	☐ Radiation Treatment	☐ Other: _____

Do you have any of the following? If yes please list, or explain.

Allergies to Anesthetics: _____

General Allergies: _____

Allergies to Medicine/Drugs: _____

Have you ever had an adverse reaction to any dental treatment? YES ☐ NO ☐

If yes please explain. _____

Are you allergic to latex? YES ☐ NO ☐

Does your Physician require you to take antibiotics prior to dental treatment? YES ☐ NO ☐

Are you under the care of a physician? _____

Please List Medications/doses you are currently taking:

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Is there anything else we should know about your medical history? _____

_____

Do you grind your teeth at night or suffer from Jaw pain? _____

Women: Do you suspect that you are pregnant? YES ☐ NO ☐

Are you taking any Birth Control? YES ☐ NO ☐

Are you nursing? YES ☐ NO ☐

When was your last dental cleaning? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature: _____Date: _____

Reverse Side ⟶

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPPA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information, and of other important matters about you protected health information. A copy of Our Notice accompanies this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Jillene Dye. Telephone #: (732) 951-0099
Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
Our Policy: Missed appointments without cancellation will result in a $35 charge. To avoid being charged please cancel your appointment 24 hours prior to your appointment.

Consent: I give consent to the following people to have access to my information below that I have checked off. Check all that apply.

Dental Records ☐ **Health History** ☐ **Referrals** ☐

Treatment Plan/Options ☐ **Insurance Information** ☐ **Account Information** ☐

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

☐ _____ **I DO NOT CONSENT**
(initial here)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____

Signature *Date*

Reverse Side →

Dentistry at South Brunswick and Your Insurance Plan – How They Work Together?
Our Office Financial Policy

The staff at Dentistry at South Brunswick is pleased that you have insurance assistance to help with the cost of your dental care. We would like to help you obtain the maximum use of your dental plan benefits. Please read the following information on our insurance claims process so that we can work together to ensure this assistance.

Do You Accept My Insurance? How Much Will They Pay?

We currently accept all private care insurance plans (plans that do not *require* you to select a dentist from a pre-determined list). We estimate your portion based on the most up-to-date information on your plan, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment.

I Thought I Paid My Portion But I Received A Bill. Why?

We base the patient portion of your bill on our most current information on your dental plan, but there are many factors that can affect this estimate. There may be an individual or family deductible or you may have received treatment in another office which is not calculated into our database. Sometimes you may need to be referred to a specialist for care, which also is applied to your annual maximum benefits. Insurance companies do not notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

Insurance Didn't Pay, Now What?

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Dentistry at South Brunswick reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. 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 cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Financial Options

Dentistry at South Brunswick requests payment in full for your portion (co-pay) at the time of service. We accept cash, check, MasterCard, American Express, Discover, and Visa. If you are in need of an extended finance option, we also work with Care Credit, Chase Healthcare Advance, and Capital One. They offer plans up to 24 months with no interest, depending on your treatment plan needs. Just ask our Financial Coordinator Jill and she will give you everything you need.

We welcome you and your family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dentistry at South Brunswick.

_____

Signature *Date*

Reverse Side →

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation. When you're finished, add up your total score at the bottom.

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting & Reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

What Does My Score Mean?

- Score of 1-6: You're getting enough sleep.
- Score of 4-8: You tend to be sleepy during the day. This is the average score.
- **Score of 9-15: You are very sleepy and should seek medical advice.**
- **Score of 16 or greater: You are dangerously sleepy and should seek medical advice.**

For information about the Epworth Sleepiness Scale and what this could mean for your health, call the Capital Health Center for Sleep Medicine at 609-584-5150.

THE PITTSBURGH SLEEP QUALITY INDEX (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. When have you usually gotten up in the morning? _____
4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed) _____

5. During the past month, how often have you had trouble sleeping because you…	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
	Very good (0)	Fairly good (1)	Fairly bad (1)	Very bad (1)
9. During the past month, how would you rate your sleep quality overall?				

Component 1	#9 Score	C1_____
Component 2	#2 Score (≤15min=0; 16-30 min=1; 31-60 min=2, >60 min=3) + #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3)	C2_____
Component 3	#4 Score (>7=0; 6-7=1; 5-6=2; <5=3)	C3_____
Component 4	(total # of hours asleep)/(total # of hours in bed) x 100 >85%=0, 75%-84%=1, 65%-74%=2, <65%=3	C4_____
Component 5	Sum of Scores #5b to #5j (0=0; 1-9=1; 10-18=2; 19-27=3)	C5_____
Component 6	#6 Score	C6_____
Component 7	#7 Score + #8 Score (0=0; 1-2=1; 3-4=2; 5-6=3)	C7_____

Add the seven component scores together _____ Global PSQI Score _____