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 will be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____

Address _____

Phone (Cell)_____ (Home)_____

Email _____

Sex ◯ M ◯ F Date Of Birth: _____ ◯ Child ◯ Single ◯ Married

Occupation _____ Employer/School _____

Notify in case of emergency _____ Phone _____

PRIMARY DENTAL INSURANCE

Insurance Company Name _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Date of Birth _____ Subscriber ID _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Princeton Premier Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

SECONDARY DENTAL INSURANCE

Insurance Company Name _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Date of Birth _____ Subscriber ID _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Princeton Premier Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you taking any medications? ◯ Yes ◯ No
(If yes, please list)

_____

_____

Have you ever had any surgical procedures? ◯ Yes ◯ No
(If yes, please list)

_____

_____

Are you allergic to any medications and/or latex? ◯ Yes ◯ No
(If yes, please list)

_____

_____

Do you have or have you had any of the following?

◯ Abnormal Bleeding
◯ Artificial Heart Valve
◯ Cancer
◯ Chemo/Radiation therapy
◯ Diabetes
◯ Drug Abuse
◯ Endocarditis
◯ Epilepsy/Seizures
◯ HIV+ AIDS
◯ Heart Attack
◯ High Blood Pressure
◯ Kidney Disease
◯ Liver Disease
◯ Low Blood Pressure
◯ Pace Maker
◯ Psychiatric Problems
◯ Stroke
◯ Total Joint Replacement (Hip/Knee)
◯ Thyroid Problems
◯ Tuberculosis

If female (Are you currently)
◯ Birth Control Pills
◯ Pregnant (# of weeks _____)
◯ Nursing

Have you ever taken medication for Osteoporosis or bone cancer treatment such as Fosamax, Actonel, Boniva, Reclast or Zometa? If yes, please list all medications:

_____

Is there any other medical/dental/psychological/developmental condition that was not mentioned in the above, we should know about, if yes please explain.

_____

I understand that the information that I have given today is correct to the best of my knowledge.
I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature of patient/parent/legal guardian Date

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 April 14, 2003, 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. **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 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 authorize 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. You may also request access by sending us a letter to the address at the end of this Notice.) 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. Restrictions: 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse To Sign This Acknowledgement**

1. I have read the above and understand the policies of the office

2. I have received a copy of this office's Notice of Privacy Practices.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

PATIENT RESPONSIBILITY AGREEMENT AND INSURANCE POLICY

We would like to take this opportunity to welcome you to Princeton Premier Dental and assure you that we will do our utmost to provide you with the best possible care. Patients (parents) are requested to pay for services **the day they are performed.** Cash, check and credit cards are all accepted forms of payment. Diagnostics, like x-rays, and treatment are rendered based on standards of care adopted by the doctor. These may conflict with insurance frequencies for coverage or patient's requested treatment desires. Ultimately, after discussion, treatment may be required to continue care. We will be glad to help you obtain the appropriate benefit from your dental insurance carrier and we will bill your carrier as a courtesy to you. However, you are responsible for resolving any problems with your insurer and are ultimately responsible for full payment of the account. We will be happy to request a pre-treatment estimate of benefits from your insurance carrier prior to completing any dental treatment if you request us to do so. Routine treatment is generally performed without submitting a request for a pre-treatment estimate of benefits.

Consent for Treatment: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize Princeton Premier Dental to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, parenthesia and other procedure specific risks.

Insurance release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment : In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein: I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection sums due and unpaid for the work herein set forth.

NO SHOW AND LATE CANCELLATION POLICY

This policy has been established to help us serve you better. It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of health care to other patients, some who need dental treatment as soon as possible.

• Patients **MUST** call/email at least **24-hours/1-Business Day** prior to their scheduled time, when they knowingly are unable to make their appointment. **Cancellations within 24 hours of appointment will be considered a late cancellation**.

• After two (2) no shows/late cancellations, the patient **will be discharged** from treatment.

• We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by the Director of Princeton Premier Dental.

• Patients will receive telephone/email reminders of appointment dates/times **1 or 2 business day(s) before to scheduled appointment** (unless patient chooses not to be called) as our courtesy. However, it is patient's responsibility to show up whether you have received the reminder or not.

• If a patient arrives more than 15 minutes late for their appointment, we have right to cancel your appointment and it will be counted as a No show/Late Cancellation.

A charge of $50.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours (Business Hours) notice is given, and no appointments will be given until the charge is paid in full.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

I have read and understand above policies and agree to its terms.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE