Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

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 incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____ Signature _____ Date _____

Dr. Robert J. Clapcich

Dental Office Financial Policies

Our office gladly accepts some dental insurance, American Express, Mastercard, Visa, Discover, Cash, Debit Cards and Checks as forms of payment for dental services. **All payments are due on the date of service.**

Dental insurance is a method of payment many people use to ***subsidize*** their dental bills. We will **assist** you in the process of your dental claims by either filing the insurance claim for you or by providing you with the completed form for you to make a claim yourself.

- If you elect to accept our assistance in filing your dental claims for you, we ask that you **completely** fill out all the appropriate sections of your claim form, sign it in black or blue ink and present the **completed** form to our receptionist. When you elect this form of assistance from us - that is, you would like our office to accept your insurance as the method of payment for your dental service - we respectfully ask you to make your **co-payments** and annual **deductibles** on the **date of service**. We want you to understand that the insurance companies hold the payments to our office for *at least* thirty days. This delay in payment can place a severe strain in our office finances if the co-payments are not received on the date of services. The insurance companies also asked that the dental office collect the co-pays and deductibles in a timely manner. Your cooperation and understanding is greatly appreciated for this small request so that our office may continue to provide you with quality service as usual. If after thirty days your insurance company has not paid it's portion , **you** will be billed for the *entire balance.*

- Please bring a claim form for **each visit** if this is a requirement of your insurance company.

- If you elect to file the claim yourself, we ask that you request the completed form from us on the date of service. When you elect this form if assistance, we ask that you pay your entire bill in full so that you can receive the payments directly from your insurance company yourself.

- If you are receiving costly services, we will make financial arrangements with you on a monthly payment schedule. This is a written contract charged at 1.8% monthly. If your bill is submitted to a collection agency for non-payment, you agree to incur all fees and charges associated with this process - both legal and administrative.

- New Patients: **Emergency Patients** who are not current patients must pay in cash or credit card only on the date of service.

- There is a $50.00 fee for broken appointments not canceled within (24) twenty-four hours. There is a $10.00 "Late Fee" for 30 day + accounts - **NO EXCEPTIONS**. Returned Check fee is $30.00. Duplication X-ray fee is $20.00.

"Your cooperation is greatly appreciated," Dr. Robert J. Clapcich.

_____ _____ _____

Print Patient's Name Signature of patient (or parent if minor) Date

Robert Clapcich, DMD

116 Millburn Avenue, #113
Millburn, NJ 07041
(973)379-2525
Fax (973)379-2014

"Creating healthy, beautiful smiles....for a lifetime."

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgment **

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Robert Clapcich, DMD. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

_____
Date of your signature

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, at:

Privacy Officer for Robert Clapcich, DMD
116 Millburn Avenue, #113
Millburn, NJ 07041
(973)379-2525
Fax (973)379-2014

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
The patient was unable to sign because	____
Other (please describe)	____

_____
Signature of privacy officer

Robert Clapcich, DMD

116 Millburn Avenue, #113
Millburn, NJ 07041
(973)379-2525
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"Creating healthy, beautiful smiles....for a lifetime."

Consent for Release of Personal & Health Information

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month, Day, Year)AAA

Address: _____
City State Zip Code

Telephone Number: (including area code) _____

Group Plan #: _____ Member ID #: _____

I authorize the use or disclosure of personal and health* information by Robert Clapcich, DMD as described below:

- ❑ Any and all personal and health information Robert Clapcich, DMD maintains (including mental health, HIV and/or substance abuse records - Cross out any item you do not authorize to be released)
- ❑ Personal and health information regarding the treatment for the following condition or injury:_____ _____ on or about_____
- ❑ Personal and health information covering the period of time_____ to _____
- ❑ Other (Please specify and include dates):_____ _____

Note: This form does not apply to disclosure of information via our web site.

This information may be disclosed to, and used by, the following individuals or organizations:

Name:_____ Relationship: _____
Address:_____
City: _____ State: _____ Zip Code: _____

Name:_____ Relationship: _____
Address:_____
City: _____ State: _____ Zip Code: _____

Name:_____ Relationship: _____
Address:_____
City: _____ State: _____ Zip Code: _____

This information is being disclosed for the following purpose(s): _____
_____
_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Robert Clapcich, DMD Privacy Office. I understand that therevocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to Robert Clapcich, DMD when the law provides it with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 365 days.

I understand that I do not have to sign this authorization and that Robert Clapcich, DMD may not condition, treatment or payment on whether I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Member or Legal Representative: _____ Date: _____

If signed by Legal Representative, relationship to Member: _____

If signed by legal representative, *please provide representative documentation as required by state law*, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.

* Health (this includes Medical, Dental & Pharmacy Information)