Welcome!

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 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 # _____

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 ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

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

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

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

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 _____

Dr Robert J. Clapcich

Dental Office Financial Policies

Our Office gladly accepts some dental insurance, American Express, Care Credit, Mastercard, Visa, Discover, Cash, Debit Cards and Personal Checks.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE, No Exceptions.

*Dental insurance is a method of payment used to subsidize your dental costs. We will assist you in the process of your dental claims. Please remember your insurance policy is a contract between you and your insurance company. We are not a party to the contract. As a courtesy to you, our office provides certain services such as pre-treatment estimates which we send to the insurance company at your request. It is physically impossible to have the 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 you or your employer has purchased.**

Please be aware 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.

We ask that Co-Payments and annual deductibles are paid at the time of service.

If your bill is submitted to collections for nonpayment, you will incur all fees and charges associated with this process, both legal and administrative including but not limited to a $199.99 collection filing fee.

There is a $50 fee for broken appointments not canceled within 24 hours. There is a $10 late fee for every 30 days your account is delinquent.

Return check fee $45

Your cooperation is greatly appreciated

Patients name_____

Patients Signature_____

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."

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)

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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