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

Date _____ Phone (____) _____ Alt. Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Sides

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:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ 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 ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

INNOVA DENTAL SOLUTIONS

APPOINTMENT POLICY

Here at ***Innova Dental Solutions*** we are committed to giving you the best quality dental care possible. Unlike many other medical/dental practices in this area, WE DO NOT overfill our appointment schedule. Scheduling in this manner has helped us give patients the individual attention they deserve and allow for completion of treatments in an efficient manner. We confirm appointments ONLY AS A Courtesy to our patients. We understand how busy everyone is, but we expect our patients to remember and keep the appointments made. If you require to change your scheduled appointment, we require a 24-hour notice. Failure to show for an appointment without giving us proper notification will result in a *broken appointment fee* of *$35.00* charged to your account. We thank you for your understanding and your commitment in helping us deliver the best care possible.

EXPLANATION OF YOUR DENTAL BENEFITS

Your dental benefits are one of the most beneficial yet misunderstood components in dental treatment today. Dental benefit is a contract between the patient's employer and the dental benefit carrier. The extent of coverage varies greatly from employer to employer, and sometimes varies by position within the company. The premium the employer is willing to pay defines the type of coverage you receive. All carriers offer a variety of plans. There is no good or bad carrier. We are ethically and professionally obligated to offer you the best possible care regardless of your dental benefit limitations. We can send as pre-treatment estimate to your carrier to accurately determine what treatment items are covered benefits.

The entire fee is the responsibility of the patient. We do our best to estimate your co-payment and expect payment in full at the time services are rendered, unless previous financial arrangements were made prior. We accept ASSIGNMENT OF BENEFITS from your insurance carrier as a courtesy for our patients. Should our estimate of your co-payment be too high, you will receive a check from us once your carrier has made its payment. If our estimate is too low, you will receive a bill for the amount not covered by your carrier.

I authorize ***Innova Dental Solutions*** to release any information to any third party necessary for the payment of any insurance claim. I authorize my insurance carrier to pay directly to ***Innova Dental Solutions*** any benefit otherwise payable to me. I agree to be responsible for payment of all services rendered to me, regardless of insurance payments.

CONSENT FOR TREATMENT

As a condition of your treatment by our office, financial agreements must be made in advance. The practice depends upon the reimbursement from patients for the cost of their care. In consideration of the professional service rendered to me I agree to pay the reasonable value of such service to the Doctor or his assignee at the time services were rendered or within five days of billing if credit should be extended to me. I further agree that the value of such services will be the amount billed. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. I agree to pay all costs and attorney's fees if suit were instituted for failure to pay my balance. In the event of default of payment, I also agree to pay legal interest on the indebtedness together with such collections costs and attorneys fees that may be required to effect collection. I grant permission for you or your assignee to contact me at home or at work to discuss any past due balance. The financial responsibility is individual and several. I assume the responsibility for charges incurred by my spouse and/or dependent children.

I have read the above conditions of treatments and payments, and agree to their contents.

Patient Name _____

Signature of patient, parent, or guardian_____ Date _____

INNOVA DENTAL SOLUTIONS

Financial Policy

As a condition of your treatment, you are responsible for all fees incurred at the time services are rendered, regardless of your insurance coverage, if any. We can do a pre-treatment estimate to dsetermine your aticipated out-of-pocket expense or we can proceed with treatment based on the general information which we have on record from your insurance carrier.

We accept the following forms of payment:

- *Cash*
- *Check*
- Credit Cards – *Mastercard, Visa , Discover, American Express*
- Health credit cards, third party – *Care Credit, Citihealth Card*

Monthly payment plans are handled through *Care Credit*

A bookkeeping courtesy is offered for treatment that is paid in full one week prior to the commencement of treatment.

For all of my out-of-pocket expenses, I elect that following option to pay for my treatment:

_____ *Cash, Check,* approved credit card

_____ *Care Credit* or *Citihealth Card*

_____ Payment in full in advance with bookkeeping courtesy

Patient signature: _____

Date: _____

INNOVA DENTAL SOLUTIONS
155 S NEW PROSPECT RD
JACKSON, NJ 08527

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

INNOVA DENTAL SOLUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____

Please Print Name

_____

Signature

_____

Date

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____

HIPPA NOTICE OF PRIVACY PRACTICES

Innova Dental Solutions
155 South New Prospect Road
Jackson, NJ 08527

Tel: (732) 364-1700 Fax: (732)364-0870

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIOM ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice or Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose s are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**
   Your Protected health information may be used and disclose by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other required law.

2. **Treatment**
   We will use and disclose your protected health information to provide, coordinate, or manage your dental health care any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as **necessary, only to ensure the referring doctor has necessary information to diagnose or treat you.**

Other Permitted and Required uses and disclosures will be made **ONLY** with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your doctor or doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The following is a statement of your rights with respect to your protected health information:
Under federal law, however, you have the right to inspect and obtain a copy of your private dental records, with the understanding that the preparation of such record will take time to prepare and also may be subject to a fee for copying such records.

Complaints:
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying and calling the office with your complaint. **We will not retaliate against you for filing a complaint.**