mint Dental
FAMILY DENTISTRY OF EMERSON

45 East Emerson Plaza, Suite 101
Emerson, NJ 07630
www.mintdentalhealth.com
(201)-977-6250

HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____
Address: ____ZIP:________

Telephone: ______________________ Email:___________________________

Social Security Number: ____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 of 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing 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 our office at the address listed on the top right of this document.

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 our office. 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 continue treating you if revoke this Consent.
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 options.

Signature: ____________________________________ **Date**: __________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: ________________________

Relationship to Patient:________________________

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NEW PATIENT INFORMATION FORM

NAME: (Last, First, Middle): ______________________________________ TITLE: _____

PREFERRED NAME: __________________ SS #:________________ DOB:____________

ADDRESS: ____

CITY:____________________________ STATE:______ ZIP: ______________

HOME PHONE: (___)___-____________ MARITAL: ____________________

WORK PHONE: (___)___-_______________ SEX: ___________

CELL PHONE: (___)___-____________________ EMAIL: __________________________

PRIMARY DENTAL INSURANCE COVERAGE

INSURED'S NAME: ___________________________ RELATION TO PATIENT ______

INSURED'S SS #: _______________________________DOB:______________________

EMPLOYER:_____________________________________

INSURANCE PLAN: ________________________ GROUP # ________________________

INSURANCE ADDRESS: ____

SECONDARY DENTAL INSURANCE COVERAGE

INSURED'S NAME: ____________________________ RELATION TO PATIENT _____

INSURED'S SS #: _______________________________DOB:______________________

EMPLOYER:_____________________________________

INSURANCE PLAN: ________________________ GROUP # ________________________

INSURANCE ADDRESS: ____

RESPONSIBLE PARTY FOR THE ACCOUNT

I understand that I am financially responsible for any deductibles, co-insurance, and/or any other service not paid or covered by my insurance company.

NAME: ____

ADDRESS: ____

SIGNATURE: ____DATE: _________________

How were you referred to our office? ____

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MEDICAL HISTORY

Correct answers to the following questions will allow our doctors to treat you on a more individual basis, providing the care appropriate to your particular needs. Circle yes or no, whoever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Patient's Name: _____________________ Date of Birth: ________

Last Physical Date: _______ Physician's Name & Phone #:________________

Reason for today's visit: ____

Work Related Injury? (circle) **Yes No** Have you been under the care of a physician? (circle) **Yes No**

Date of last dental visit: ___________ Have you ever been hospitalized? (circle) **Yes No**

Date of last dental x-rays: _________ Ever had Novocaine or other local anesthetic? (circle) **Yes No**

If wearing dentures, age of dentures: ______

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes No**

Are you taking or have taken Oral Bisphosphonates, e.g., **FOSAMAX, ACTONEL, BONIVA**, **or IV Bisphosphonates**, e.g., **ZOMETA, AREDIA**? (circle) Yes No Taken for how long? __________

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes No**

List any medications you are allergic to:

1.____________________2.___________________3.__________________4._______________

List any medications you are taking including non-prescription drugs including herbals/vitamins:

1.____________________2.___________________3.__________________4._______________

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Do you have history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
			Asthma			Epilepsy or Seizures		
Rheumatic Fever			Allergies or Hives			Fainting or Dizzy Spells		
Heart Murmur			Anemia			Ulcers or Stomach Problems		
Mitral Valve Prolapse			Aspirin / Anticoagulant Therapy			Arthritis		
Diabetes			Venereal Disease			Latex Allergy		
Pace Maker/Heart Surgery			HIV Positive / Aids			Sinus Problems		
High Blood Pressure			Blood Transfusion			Cancer (Type:)		
Low Blood Pressure			Excessive Bleeding			Chemotherapy		
Heart Problem ( )			Hepatitis (Type:)			Radiation Treatment		
Stroke			Liver Disease			Use of Tobacco Products		
Lung Disease			Kidney Disease			Drug Addiction		
Breathing Problems			Dialysis			Alcoholism		
Tuberculosis (TB)			Thyroid Disease			Psychiatric Treatment		
Mouth Sores / Growths			Teeth Grinding / Clenching			Pain in your jaw (TMJ)		
Any type of Implant			Any type of Transplant			Any Artificial Hip, Knee or other Joint		
Other Disease or Illness:								

Women	**Y**	**N**		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date:			Are you taking any birth control prescriptions?		
NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.					

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Signature of Patient / Guardian: ________________________________ **Date**: ______________

Signature of Dentist _________________________ **Date**: ________

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OFFICE GUIDELINES

If you have dental insurance we will gladly process your claim but we request that you pay your *estimated* out of pocket when services are rendered.

If you do not have insurance, payment is expected at the time services are rendered, unless prior financial arrangements have been made.

There is a $50.00 cancellation fee for all appointments with our doctors not cancelled at least 24 hours in advance.

***I have read and understand the office guidelines of Mint Dental – Family Dentistry of Emerson as stated above*.**

Signature: ____ ***Date***: _________________