PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Medical History for New Patient

Last Name: _____ First Name: _____Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

_____

_____

_____

_____

_____

List all Surgeries:

_____

_____

_____

Allergies: _____

_____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE CHECK BELOW)

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Artificial Joints / Heart Valves
- ☐ Rheumatic Fever
- ☐ Prolonged Bleeding
- ☐ Anemia
- ☐ Abnormal Blood Pressure
- ☐ Ulcers
- ☐ TB or Lung Disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid
- ☐ Jaw Pain / Tired Jaw Muscles
- ☐ Dizziness / Loss of Balance
- ☐ Earaches
- ☐ Ear Stuffiness / Loss of Hearing
- ☐ Ringing in Ears
- ☐ Neck Pain
- ☐ Headaches / Migraines / Facial Pain
- ☐ Clenching / Grinding
- ☐ Change in Bite
- ☐ Jaw Locking / Catching
- ☐ Jaw Clicking / Popping
- ☐ Snoring
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Cough
- ☐ Arthritis
- ☐ Stroke
- ☐ Glaucoma
- ☐ Aids / Aids Related Complex
- ☐ Psychiatric Treatment

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a Panoramic X-rays or Full Mouth x-ray that are less than 5 years old? _____

Do you have BiteWing x-ray that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

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 of the doctors and/or assistants. I authorize the dentist to release any information including diagnoses 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 other 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 on my dependents.

I am aware that there will be broken appointment fee if I fail to give 24 hr. notification of a cancellation.

_____

Signature of patient or parent if minor Date

Wayne Family Dental
931 Hamburg Turnpike, Wayne, NJ 07470
973•694•4494

Dental Patient Screening Form

Patient Name:

_____

(First) (Last) (Birthdate)

	Pre-Appointment Self-Assessment Date:	OFFICE USE ONLY Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	[ ]Yes [ ] No	[ ] Yes [ ] No
Are you/they having shortness of breath or other difficulties breathing?	[ ] Yes [ ] No	[ ] Yes [ ] No
Do you/they have a cough?	[ ] Yes [ ] No	[ ] Yes [ ] No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	[ ] Yes [ ] No	[ ] Yes [ ] No
Have you/they experienced recent loss of taste or smell?	[ ] Yes [ ] No	[ ] Yes [ ] No
Have you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment	[ ] Yes [ ] No	[ ] Yes [ ] No
Is your/their age over 60?	[ ] Yes [ ] No	[ ] Yes [ ] No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	[ ] Yes [ ] No	[ ] Yes [ ] No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (As relevant to your location)	[ ] Yes [ ] No	[ ] Yes [ ] No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

Wayne Family Dental
931 Hamburg Turnpike, Wayne, NJ 07470
973•694•4494

WRITTEN FINANCIAL POLICY

Thank you for choosing Wayne Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible for our patients by offering several payment options.

Payment Options:

You can choose from:

- Cash, check, Visa, MasterCard or Discover Card
- Convenient Monthly Payment Options* from CareCredit Healthcare Credit Card
  Allow you to pay over time with no annual fees or prepayment penalties

Please Note:
Wayne Family Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. **

A fee of $40.00 per half hour is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Wayne Family Dental charges $50.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print) Date

subject to credit approval

**However, If we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection from your insurance carrier.

Wayne Family Dental
931 Hamburg Turnpike, Wayne, NJ 07470
973•694•4494

What Happens If I Miss An Appointment?

Last Name: _____ First Name: _____

Birthdate: _____

PLEASE give our dental office 24 hours" notice if you need to cancel or reschedule an appointment. I you fail to do so, or arrive more than 15 minutes late, you will be charged a broken appointment fee of up to $80.00, depending on the length of your missed appointment.

Keep in mind, that as a courtesy, our office calls you in advance to reconfirm your appointment

.....

I have read the above policy and agree to its terms:

_____

Signature Date

Wayne Family Dental
931 Hamburg Turnpike, Wayne, NJ 07470
973•694•4494

Notice of Privacy Policies

Last Name: _____ First Name: _____

Birthdate: _____ Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices.
I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature Date