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 Information (CONFIDENTIAL)

Patient # _____
SS #/SIN _____
Date _____

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. _____
Profession _____ 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. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

7. 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 _____	☐	☐

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?	☐	☐

	Yes	No
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 if minor)

24-Hour Cancellation Policy:
Please provide at least 24 hours-advanced notice or you will be charged a cancellation fee. _____ (Initials)

Medical Changes Update-Date-Initial _____

Doctor's Comments _____

_____ Signature _____ Date _____

Life Family Dentistry
"Smiles that last a Lifetime"
Michael Leyferman, D.M.D.
403 Route 202, Flemington, NJ 08822
908.782.4443

OSTEONECROSIS ALERT AND INFORMED CONSENT

Some patients taking certain medications containing chemical bisphosphonates to prevent osteoporosis, or to treat cancer, have developed severe complications with surgery. Fosamax, Actonel, Boniva, Aredia and Zometa are several of these drugs.

Please inform the doctor if you have taken any of these medications.

Thank you.

I have NOT taken these drugs:

Print Name: _____

Signature: _____

I have taken these drugs:

Print Name: _____

Signature: _____

Today's Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the LIFE FAMILY DENTISTRY Notice of Privacy.

Please Print Name: _____

Signature: _____

Date: _____

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

Personal Representative's Name: _____

Relationship to patient: _____

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

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (Please Specify): _____

Notice of Privacy Practices

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Health Information Privacy Act Notice - Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that the U.S. government regulators established a privacy rule governing protected health information (PHI). This notice tells you about how it may be used, and about certain rights you have.

We have a designated privacy contact person handling all privacy matters in our office. You can contact her at this office if you desire further information, or have any questions or concerns. Additionally a more detailed notice of our privacy notice is available to you both in the reception area and from our front desk staff.

Use and disclosure of protected health information (PHI):

Federal law provided that we may use your PHI for treatment of you, without further specific notice to you, or written authorization by you. For example, we are required by health insurance plans to provide them with a diagnosis code for your visit, and a description of services rendered.

Federal laws provide that we may use you medical information for office purposes without further specific notice to you, or written information by you. For example our accountants may see your name, dates of treatment and procedure codes during audit of our books.

We may use or disclose you medical information, without further notice to you, or specific authorization by you where:

1. Required by law.
2. Required for public health purposes.

3. Required by law to report a child or elder abuse.
4. Where required by a health oversight agency for oversight activities authorized by law, such as the department of health, office of professional conduct.
5. Required by law in a judicial or administrative proceedings.
6. Required for law enforcement purposes.
7. Required by a coroner or medical examiner.
8. Permitted by law to a funeral director.
9. Permitted by law for organ donation purposes.
10. Permitted by law to avert a serious threat to health or safety.
11. Permitted by law and required by military authorities if you are a member of the armed forces of the U.S.

New Jersey state law provides additional protection for information regarding HIV/AIDS. We will continue to follow New Jersey state law with respect to such information.

We may contact you by mail or phone at your residence, to provide information about your treatment. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

Other uses or disclosures of medical information will be made only with your written authorization. For example, you will need to execute an authorization form before we can send your x-rays or PHI (protected health information) to a life insurance.

We prefer to have you pick up copies of your PHI in such instances, since fax machines are not an absolutely "secure/private" means to transmit your PHI.

If you wish to complain about violations of your privacy rights, you have a right to file a complaint with the secretary of the department of health and human services of the United States. You may also file a complaint with us by contacting our office and asking to speak to the privacy contact at (908) 782-4443.

No retaliatory action will be taken against you for any complaint you may make.

We request that you sign a statement that you have received a paper copy of this notice for your records. It is federal law that this signed statement be kept in your dental chart.