

Dear Friend,

Thank you for choosing me as your general dentist. I will personally do everything possible to deserve your trust. I see this as the beginning to a great relationship.

It is important that you know I treat each patient one at a time to give the utmost attention and care, giving time to listen to your concerns and make an accurate diagnosis to your problem. I also look forward to partnering with you to achieve and maintain a beautiful healthy smile.

I do realize that dental emergencies can be stressful when they happen to you or someone you love. To help alleviate some of your concern, I promise to respond to your telephone calls promptly.

In today's busy world I understand the frustration to sit in a waiting room past the time of your appointment. My staff and I are dedicated to do our best to get you started on time for your scheduled appointment.

As your dentist, I realize it is my responsibility to keep up with the latest developments in cosmetic and restorative dentistry. That is why I take continuing education courses and retain active membership in several professional dental organizations.

But even more important than all of my training and experience, is the 100 plus years experience that my staff and I have collectively in the field of dentistry. I am very proud of our dental team and the many years we have been together helping our patients feel comfortable and cared for in our office.

So why do I do these things? The answer is simple. I want to build a lasting relationship with you. It is my goal that when you come to see me you'll feel really good about every aspect of your experience and happy that you chose me for your dental care.

Sincerely,

DawnMarie DiGrazia, D.M.D

**WELCOME TO
SOMERSET DENTAL ARTS**

Date_____ Home Phone _____ Cell Phone _____

Patient Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Email _____ Male _____ Female _____ Birth date _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Emergency Contact _____ Relation _____ Phone _____

Whom may we thank for referring you? _____

Do you have Dental Insurance? _____ Name of Carrier _____

Subscriber's name _____ Relation to Patient _____

SS# _____ Group# _____ Ins. ID# _____

Date of Birth _____ Employer's name _____

Employer Address and Phone _____ Ins. effective date _____

AUTHORIZATION:

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand and have been informed the uses and disclosures of all of my health information to be shared at the discretion of the dentist. (HIPPA Compliance)

I UNDERSTAND that I AM FINANCIALLY responsible for all fees and charges incurred at Somerset Dental Arts whether or not paid by Insurance.

SIGNATURE _____ DATE _____

Eaglesoft Medical History (Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics

Other?

☐

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No
Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No	Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No
Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above?

☐ Yes ☐ No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:

SOMERSET DENTAL ARTS

Policy on Financial Arrangements

It is our goal to ensure that each one of our patients receives the highest quality dental care that we can provide. In order to achieve this goal for you, we are happy to offer (if needed) viable options for your financial arrangements with our office.

Payment is due in full at the time treatment is rendered. We accept cash, check, debit cards and all major credit cards. Our office accepts assignment on your dental insurance and will handle processing your claim. If extended time is needed to pay for treatment, CareCredit provides a monthly financial payout option which allows you to start your dental treatment today.

PAYMENT OPTIONS:

FULL PAYMENT:

Payment in full by cash, check, debit card, and all major credit cards is expected the day treatment is rendered.

Senior Courtesy of 5% is given to all patients 65 and over.

INSURANCE ASSIGNMENT:

Our office will submit your insurance claim for you. We will help you to understand your dental coverage and your co-pays. Partial or full payment of co-pays is due when services are rendered.

MONTHLY PAYMENTS:

We offer a monthly payment option through *CareCredit*, a financing company specific to your healthcare needs. You can apply for *CareCredit* right here in our office and receive approval within minutes. This financing option has no annual fee, can be used at other healthcare offices, and has a variety of payment options, some no interest. **Ask us about *CareCredit* today.**

EXTENSIVE TREATMENT COURTESY:

For treatment that exceeds \$1800, we can extend a courtesy of 8% off the total cost of treatment if payment is made in full at the first appointment of treatment (before treatment begins). Payment must be made by cash or check only, NO credit/debit cards.

Please note: We cannot extend more than one courtesy at a time.

NOTICE OF PRIVACY PRACTICES

SOMERSET DENTAL ARTS
279 East Main Street
Somerville, NJ 08876

This notice describes how dental information about you may be used and disclosed in our office, and how you can get access to this information.

PLEASE REVIEW THIS INFORMATION CAREFULLY

The *Health Insurance Portability & Accountability Act of 1996* ("HIPAA") is a federal program that requires that all medical/dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used.

USES AND DISCLOSURES OF HEALTH INFORMATION

Our office may use and disclose your dental records only for the following purposes; treatment, payment and health care operations (TPO). TPO activities would include managing and coordinating your dental treatment plan with one or more healthcare providers, obtaining reimbursement for services, gathering insurance information, billing or collections activities and utilization review. It would also include the business aspects of running our practice, such as calling patients at home and/or at work (including leaving voice messages) in reference to any aspect of the practice of carrying out the TPO, sending appointment reminders by mail, filing insurance claims, coordinating laboratory work, and providing information to our patients about health-related benefits and services that may be of interest to you.

Any other uses and disclosures of your protected health information (PHI) will be made only with your written authorization. You may revoke this authorization in writing at any time, which our office will honor unless actions were already taken based on your previous consent.

PATIENTS RIGHTS

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to our office. This includes access to review or obtain copies of your PHI, with limited exceptions. A reasonable cost-based fee for expenses such as copies and staff time will accompany all requests for copies. You may request the PHI be in a form other than a photocopy, which will be honored unless we cannot practically do so.

You have the right to request that additional restrictions be placed on the use and disclosure of your PHI. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in an emergency).

You have the right to request that we communicate with you about your PHI by alternative means or locations. Your request must be very specific and detailed and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

You have the right to receive an accounting of disclosures of your PHI, not to date prior to the effective date of the new HIPAA Privacy Practices in our office.

You have the right to request that we amend your health information. Again your request must be in writing, and we hold the right to deny your request under certain circumstances.

You have the right to obtain a paper copy of this notice from us upon request.

QUESTIONS AND COMPLAINTS

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post these changes and you may request a written copy of our revised policy from our office.

If you want more information about our privacy practices or have questions or concerns, please notify us.

If you are concerned that we may have violated your privacy rights, or disagree with any decision we made concerning the use and disclosure of your PHI, or as it pertains to your patient rights, you may submit a formal complaint to our office in writing or file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.