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_____

MEDICAL HISTORY

Do you have any general health problems? Y/N _____

Physician's Name: _____ Date of last Visit_____

Have you had any serious illnesses/ operations? Yes___ No___ Yes, please describe

_____

Have you had a blood transfusion? Yes_____ Give Date_____ No_____

WOMEN: Are you Pregnant? _____ Nursing?_____ On birth control pills?_____

CIRCLE if you have or have had any of the following:

Anemia	Blood Disorders	Hepatitis	Sinus Trouble
Arthritis	Cough, persistent	High Blood Pressure	Shortness of Breath
Artificial Joints	Lyme disease	HIV/AIDS	Snoring/ Sleep Apnea
Artificial Heart Valve	Diabetes	Organ Transplant	Stroke
Asthma	Epilepsy	Kidney Disease	Swelling feet/ankles
Back Problems	Fainting	Liver disease	Thyroid Problems
Cancer	Glaucoma	Mitral Valve Prolapse	Tobacco Habit
Chemical Dependency	Headaches	Pacemaker	Tuberculosis
Chemotherapy	Heart Problems	Respiratory Disease	Osteoporosis
Circulatory Problems	Hemophilia	Rheumatic Fever	Venereal Disease

OTHER: _____

MEDICATIONS: List all you are currently taking_____

ALLERGIES TO MEDICATIONS, please list_____

DENTAL HISTORY

When was your last dental exam?_____ Last dentist? _____

Are your teeth sensitive to: Hot_____ Cold_____ Sweets_____ Biting _____

Does food catch between your teeth? _____ Gums bleed when brush? _____

Any gum swelling around your teeth? _____ Unpleasant odor in your mouth? _____

Problems with your Jaw clicking _____ pain____ opening or closing____ chewing_____

Do you ever avoid any part of the mouth while brushing? _____

Are you dissatisfied with your teeth & their appearance? _____

Are you deeply concerned about the finances required for your dental health _____

Do you get frustrated always needing dental work when you visit the dentist? _____

Do you smoke? _____ Have you had a reaction to anesthetic? _____

Have you had teeth removed? _____ How long have these teeth been missing? _____

Do you feel you will eventually wear dentures? ___ Do you have any fears? _____

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.

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the office today because you have an urgent dental condition that must be treated at this time and cannot be postponed until the current COVID-19 risk period abates. Please be advised of the following:

While our office compiles with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

---------- ----------

PATIENT/RESPONSIBLE PARTY **DATE**

PLEASE ANSWER WITH "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

DO YOU HAVE A FEVER? ____YES ____ NO

DO YOU HAVE ANY SHORTNESS OF BREATH? ____YES ____ NO

DO YOU HAVE A DRY COUGH? ____YES ____ NO

DO YOU HAVE A SORE THROAT? ____YES ____ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELED TO ANY FOREIGN COUNTRY ____YES ____ NO

WITHIN THE LAST 30 DAYS, HAVE YOU TRAVELED WITHIN THE US? ____YES ____ NO

IF SO WHERE? _____