RED BANK SMILES
FAMILY DENTISTRY

Benjamin B. Klayman, DMD
180 RIVER ROAD, RED BANK NJ 07701
732-741-1052
www.redbanksmilesnj.com

WELCOME TO RED BANK SMILES! PLEASE, TAKE A MOMENT TO PROVIDE US WITH THE FOLLOWING INFORMATION

I. PATIENT INFORMATION

*NAME:*_____

*Name you prefer to be called by, or pronunciation:*_____

*BIRTHDATE:*____/____/____ *SEX: M / F* *SS#:*_____

II. CONTACT INFORMATION

*ADDRESS:*_____

*CITY:*_____ *STATE:*_____ *ZIP:*_____

*LAND LINE:*_____ *CELL PHONE:*_____

*EMAIL:*_____

Preferred method of contact: LAND LINE CELL TEXT EMAIL

If you do not have an answering machine, please provide us a way to leave a message:

III. OTHER INFORMATION

MARTIAL STATUS: S M D W

*EMERGENCY CONTACT NAME:*_____ *RELATIONSHIP:*_____

*ADDRESS:*_____

*CITY:*_____ *STATE:*_____ *ZIP:*_____

*LAND LINE:*_____ *CELL PHONE:*_____

*EMAIL:*_____

IV. RESPONSIBLE PARTY

SAME AS PATIENT: Y / N

*If not, NAME:*_____ *RELATIONSHIP:*_____

*SS#:*_____ *BIRTHDATE:*____/____/____

*ADDRESS:*_____

*CITY:*_____ *STATE:*_____ *ZIP:*_____

*LAND LINE:*_____ *CELL PHONE:*_____

*EMAIL:*_____

Is there a friend or family member who is also a member of our practice?

How did you hear about us?

V. INSURANCE INFORMATION

Primary Carrier
*INSURANCE COMPANY:*_____

*GROUP #:*_____ *POLICY #:*_____

*ID#:*_____

If Insured is not Patient, please provide Insured Name:

*ID#:*_____ *SS#:*_____

*BIRTHDATE:*____/____/_____

*RELATIONSHIP TO PATIENT:*_____

*EMPLOYER NAME:*_____

What is your deductible amount?
What is your maximum annual benefit?

Seondary Carrier
*INSURANCE COMPANY:*_____

*GROUP #:*_____ *POLICY #:*_____

*ID#:*_____

If Insured is not Patient, please provide Insured Name:

*ID#:*_____ *SS#:*_____

*BIRTHDATE:*____/____/_____

*RELATIONSHIP TO PATIENT:*_____

EMPLOYER NAME:_____ *What is your maximum annual benefit?*

What is your deductible amount?

As payment is due in full, please provide a payment a Credit Card to retain:

VI. EMPLOYER INFORMATION

OCCUPATION:_____

EMPLOYER ADDRESS:_____

CITY:_____ *STATE:_____* *ZIP:_____*

LAND LINE:_____ *CELL PHONE:_____*

EMAIL:_____

SIGNATURE:_____

DATE: _____

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Dental History

*WHAT CAN WE DO TO MAKE YOUR TIME WITH US A FANTASTIC EXPERIENCE?*_____

_____

_____

*WHAT WOULD YOU LIKE US TO DO TODAY?*_____

_____

_____

*HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR SMILE?*_____

_____

_____

*PLEASE, TELL US ABOUT YOUR HOMECARE:*_____

_____

_____

PLEASE, CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Sensitivity/pain to: sweets biting hot cold

Headaches Migraines Clenching Grinding

Head/Neck Injuries Clicking/Popping Jaw

Sores/growths Bad Breath Bleeding Gums Food Impaction

*FORMER DENTIST:*_____

*DATE OF LAST VISIT:*_____*DATE OF LAST X-RAYS:*_____

*IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW?*_____

_____

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Health History

*NAME OF PERSONAL PHYSICIAN:*_____

*DATE OF LAST VISIT:*_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? Y / N
If yes, please tell us more about that: _____

_____

_____

HAVE YOU BEEN DIAGNOSED WITH ANY DISEASES OR ILLNESSES? Y / N
If yes, please tell us more about that: _____

_____

_____

PLEASE LIST ANY OVER-THE-COUNTER OR PRESCRIPTION MEDICATIONS YOU TAKE:

_____

_____

_____

PLEASE LIST ANY ALLERGIES YOU ARE AWARE OF: _____

_____

_____

DO YOU USE TOBACCO? Y / N
If yes, please tell us more about that: _____

ARE YOU PREGNANT? Y / N *ARE YOU NURSING? Y / N*

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Use and Disclosure of Protected Health Information Consent

Use of this form is optional and not required under the HIPAA privacy rule.

I hereby give my consent for Red Bank Smiles to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Red Bank Smiles describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Red Bank Smiles reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Benjamin Klayman, 180 River Road Red Bank, NJ.

With this consent, Red Bank Smiles may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Red Bank Smiles may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Red Bank Smiles may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Red Bank Smiles restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Red Bank Smiles to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Red Bank Smiles may decline to provide treatment to me.

Patient's Signature _____

Date _____

Print Name _____

Legal Guardian _____

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Photograph and Publicity Release Form

I give my permission to use my name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of Red Bank Smiles activities. I agree that Red Bank Smiles has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with Red Bank Smiles' mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc for the use of such pictures, etc., and hereby release Red Bank Smiles and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.
I have read and understood this consent and release.
I give my consent to Red Bank Smiles to use my name and likeness to promote the program, its fiscal agent, and/or their activities.

Patient's Signature _____

Date _____

Print Name _____

Legal Guardian _____
I do not give my consent to Red Bank Smiles to use my name and likeness to promote the program, its fiscal agent, and/or their activities.

Patient's Signature _____

Date _____

Print Name _____

Legal Guardian _____

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The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of sleepiness. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

Please rate your chances of dozing off in the following situations, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

No chance of dozing =0
Slight chance of dozing =1
Moderate chance of dozing =2
High chance of dozing =3

Write down the number corresponding to your choice:

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (e.g., a theater or a meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit_____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

Total Score = _____

Analyze Your Score

0-7:It is unlikely that you are abnormally sleepy.

8-9:You have an average amount of daytime sleepiness.

10-15:You may be excessively sleepy depending on the situation. You should consider seeking medical attention.

16-24:You are excessively sleepy and should seek medical attention.