RED BANK SMILES
21st CENTURY FAMILY DENTISTRY
180 River Road, Red Bank NJ 07701
www.redbanksmilesnj.com
732-741-1052

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 deductible amount?
What is your maximum annual benefit?

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?*_____

_____

_____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH/GUMS/SMILES? *Y / N*

WOULD YOU LIKE TO DISCUSS ENHANCING THE APPEARANCE OF YOUR SMILE? *Y / N*

WOULD YOU LIKE TO DISCUSS HOW TO MAKE YOUR TEETH WHITE? *Y / N*

*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 _____