



RED BANK SMILES
21st CENTURY FAMILY DENTISTRY

180 River Road, Red Bank NJ 07701
www.redbanksmls.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?*

Secondary 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 _____