180 River Road
Red Bank, NJ 07701
www.redbanksmilesnj.com
732-741-1052

New Patient Intake

Date:_________
Team Member: ____________________
Appointment Date: ________________

1. PATIENT INFORMATION

*NAME:*____

Preferred name or pronunciation: ____

DOB: _______/______/______ *SEX*: M / F *SS#*: _______________________

Who may we thank for the referral?

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

How can we help you?

Date of last dental visit?
Date of last x-rays?
Type of x-rays?

2. CONTACT INFORMATION

HOME: __________________________

CELL: ___________________________

WORK: __________________________

EMAIL: ____________________________

ADDRESS: ____

CITY: ______________________________ *STATE:* ______________ *ZIP:* __________
____

So that we can make your visit as comfortable as possible, is there anything else you want us to know?

3. OTHER INFORMATION

MARTIAL STATUS: S M D W

*EMERGENCY CONTACT NAME:*_____________________________ *RELATIONSHIP:*_________

*ADDRESS:*____

*CITY:*____________________________ *STATE:*_________ *ZIP:*____________

*LAND LINE:*______________________________ *CELL PHONE:*____________________
*EMAIL:*____

4. 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:*____

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 ______________________________