JOSEPH M. MANERI, D.M.D.

67 Lacey Rd., Suite 1
Whiting, NJ 08759
732-350-2100

Please Print

Date_____

Patient Information

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Insurance Co. _____

Address of Ins. Co. _____

Group # _____ ID # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Address of Ins. Co. _____

Group # _____ ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

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Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

Health History

Physician's Name _____ Date of last visit _____

Have you ever been told to premedicate with an antibiotic prior to dental treatment for a medical reason? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally, with			Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
What type? _____			Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
When? _____			Kidney Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			

Are you currently or have you ever taken medicaton for osteoporosis? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Patient's Signature _____ Date _____

JOSEPH M. MANERI, DMD

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. We are required by law to maintain the privacy of protected health information (PHI) and provide patients with this notice of our legal duties and privacy practices with respect to PHI. There are rules and restrictions on who may see or be notified of your PHI. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services, www.hhs.gov or we can offer you a more complete version of the copy of the law.

Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This specifically includes the sharing of information with other health care providers and insurance companies as it is necessary and appropriate for your care.

It is the policy of our office to remind our patients of their scheduled appointment via telephone. We will leave a message on the answering machine if no one is available to answer the phone. We also mail reminder postcards when the patient is due for an office visit.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form.

Name:_____ Birthdate: _____

Signature: _____ Date: _____

I authorize the following individual(s) to receive information regarding my dental treatment or billing issues:

Name:_____

Relationship:_____ Phone Number: _____