PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SS #/SIN _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
5. DO YOU USE TOBACCO?	☐	☐
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (E.G. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____
☐	☐	THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			_____

COMMENTS

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

(PLEASE PRINT)

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

Daniel C. Schwartz DDS & Associates
Family and Cosmetic Dentistry
614 Sicklerville Road
Williamstown, NJ 08094
Phone: 856-728-9494
Fax: 856-723-0019

Patient Information Form

Name: _____ **Date of Birth:** _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____ **Extension #:**_____

Address:_____

Social Security Number:_____

Changes in Medical History: YES or NO Medications:_____

DENTAL HISTORY:

Do you wear Dentures/Partials? _____ **How old are they?** _____**Do you have any crowns or bridges?** _____**How old are they?** _____

Nearest relative not living with you: _____

Insurance Policy Holder: _____

Policy Holder Employer: _____

Policy Holder Social Security Number: _____

Whom may we thank for referring you to us?: _____

Name: _____ **Address:** _____**Phone:**_____

Responsible party if patient is a minor: _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for all professional services rendered. I have read all the information on this form and completed the above questions. I will notify you of any changes in my insurance status or any of the above information.

_____ _____

Signature **Date**

_____ _____

Signature of Parent (if a minor) **Date**

Daniel C. Schwartz, D.D.S & Associates
Family & Cosmetic Dentistry
614 Sicklerville Road, Williamstown, NJ 08094
Phone: 856-728-9494 Fax: 856-728-0019

This is an agreement between Dr. Daniel Schwartz or associate, as creditor, and the patient named on this form.

In this agreement the words **"you," "your," and "yours"** refer to the patient. The word "account" means this account has been established in your name to which charges are made and payments are credited. The words **"we," "us," and "our"** refer to Dr. Daniel Schwartz or associate.

By signing this agreement, you are agreeing to pay for all services that are received.

Payment options if have no insurance are as follows:

A: On treatment involving laboratory fees (crowns, bridges, dentures, partials, etc.) you may choose to pay half on the preparation date and the balance on the completion date.

B: We offer special financing through Care Credit or Citi Bank. No interest charges if paid with in 3, 6 or 12 months. This includes an additional merchant's fee percent.

Payment options if you have dental insurance are as follows:

On extensive treatment (crowns, bridges, dentures, partials, etc.) you may choose to pay half on the preparation date and the balance on the completion date.

> ***Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we ESTIMATE what your insurance company may pay, it is the insurance company that makes the final determination of your co-payment. You are responsible for any fees that are not covered under your insurance plan & in the case if a procedure is downgraded no matter what fees are given to you at the time of service.***

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement; therefore, we cannot bill you for these.

Returned Checks: There is a fee ***(currently $25)*** for any checks returned by the bank.

Missed/Cancelled Appointment Fee: Patients who do not show up or cancel an appointment Monday – Friday, or cancel with less than 24 hour notice will be charged a $50 fee. This fee must be paid before the new appointment is scheduled. The second time this occurs, a $50 fee will be charged. Patients with three missed appointments will be asked to transfer their records to another doctor. Appointments missed or cancelled on Saturday will be charged a $70 fee.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay us all of the collection costs and late fees which occur. If we have to refer collection of the balance to a lawyer, you agree to pay all of the lawyer's fees plus all court costs.

Waiver Of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have litigate in court, or if your past due payments are reported to a credit agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In a case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the patient authorizing treatment for a child will be responsible for the charges. If the divorce decree requires the other parent to pay any of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring Records: You will need to request in writing, and pay a fee ***(currently $35)*** if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive relevant information, including your payment history.

Effective Date: Once you have signed this agreement, you agree to all of the terms contained herein and the agreement will be in effect.

Patient's Name: _____ **Signature:** _____

Date: _____ **Guardian/Responsible Party:** _____

Daniel C. Schwartz, DDS & Associates
Family and Cosmetic Dentistry
614 Sicklerville Road
Williamstown, NJ 08094
Phone: 856-728-9494
Fax: 856-728-0019

Notice Of Private Practices

The notices given prior to this form explain how we are handling your privacy as our patient in the office. You are entitled to designate with whom we can or can not discuss your treatment and financial information with. As with this new law, you are entitled to full privacy of your records. Please list the people we can discuss your account with. For example, if your spouse takes care of finances and calls in regards to a statement he/she has received, the patient must list this person on this form in order to discuss your personal information. This does not include patients 18 years of age, even though they still may be covered under their parent's insurance plan and the parents are still paying for their bill, the patient must list their parents on this paper. Keep in mind **this is for your privacy and protection**, and we will do everything that we can to keep your information safe and secure. If you have any questions, or would like a more detailed explanation of this form, please do not hesitate to ask any one of our staff members.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Treatment information only

☐ Financial information only

☐ Both treatment and financial information

Print: _____ Sign: _____ Date: _____

☐ ***If you do not want us to discuss any of your information with anyone, please check this box, sign and date. Thank you.***

FAMILY AND COSMETIC DENTISTRY

DANIEL C. SCHWARTZ, DDS

614 Sicklerville Road

Williamstown, NJ 08094

NOTICE: TO ALL INSURANCE PATIENTS

Our office participates with most major insurance companies. Our staff is trained to help you with your insurance. We have a special program on our computer to help us collect your portion of your dental bill "as close as possible". However, it is NOT possible for us to know every fee, therefore, you will be billed for the remaining balance after the insurance pays their portion.

We receive many calls from patients stating "your front desk girl told me what I owe and I paid that amount at the time of my office visit." This service is for the patient. Many offices require the patient to pay the entire bill and then the patient submits the form and is reimbursed by the insurance company.

We also are NOT responsible for your maximum. If you feel you are close to reaching your maximum, please ask one of our insurance coordinators and they will research this for you. You are also welcome to call your insurance company yourself to get this information.

Please be advised that the dentist and hygienist are serving your dental needs and are NOT responsible for what your insurance company pays. The patient is responsible for the bill. We will submit to the insurance company for you, however, whatever the insurance company does not pay, it is the patient's responsibility to pay the balance.

We suggest you know your benefits. If you are not sure, we will do our best to help you.

Signature Date