PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Alt. Phone (____)_____ Email address:_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security # _____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (____)_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ HIV / AIDS or Other Immunosuppressive Disorders
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, please describe _____

_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

EAST BRUNSWICK NEW IMAGE DENTAL,LLC
J.WOO,D.D.S
444 RYDERS LANE
EAST BRUNSWICK, NJ 08816
(732) 432-8388

CONSENT FOR USE/ DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

Patient's date of Birth:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Please review the Privacy Practice Notice in our office before signing. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights to you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To be completed by Patient or Patient's Representative)

I,_____, have read the contents of this Consent form and the Notice Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's signature or Signature of Patient's representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows;

Name of Privacy Officer: Kathy Shin

Practice address: 444 Ryders Lane
East Brunswick, NJ 08816

Phone: 732-432-8388 Fax: 732-432-8366

East Brunswick New Image Dental LLC
Dr. J. Woo, DDS
444 Ryders Lane
East Brunswick, NJ 08816

Acknowledgement of Receipt of Late Cancellation Fee Policy

I, _____, have read and understand the Late Cancellation Fee Policy at New Image Dental at East Brunswick.

I understand I will be responsible for a $25.00 late cancellation fee if I do not call to cancel my appointment with at least 24 hours notice.

I understand that repeated late cancellations/no-shows will keep me from receiving highly demanded appointment times such as evenings and weekends.

Patient / Guardian Signature: _____ Date: _____

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