Twenty-First Century Dental, P.C

4001 Asbury Avenue Suite 1
Tinton Falls, NJ 07753
732-922-1060

2701 Bridge Avenue
Point Pleasant, NJ 08742
732-701-3540

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Employer Name:

_____

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Twenty-First Century Dental, P.C

4001 Asbury Avenue Suite 1
Tinton Falls, NJ 07753
732-922-1060

2701 Bridge Avenue
Point Pleasant, NJ 08742
732-701-3540

Medical Infomation

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Allergy - Sulfa
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ MVP
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Tumors
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - NOVOCAINE
- ☐ Allergy-metals
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis A
- ☐ HIV +
- ☐ Low Blood Pressure
- ☐ Nervous Disorders
- ☐ PhysicallyChallenged
- ☐ Rheumatism
- ☐ Stroke
- ☐ Ulcers
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Blood Thinners
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Hepatitis B
- ☐ Jaundice
- ☐ Mentally Challenged
- ☐ NO EPINEPHRINE!
- ☐ PreMed not needed
- ☐ SEE CHART
- ☐ Thyroid
- ☐ Venereal Disease
- ☐ ADHD
- ☐ Allergy - Hay Fever
- ☐ Allergy - Penicillin
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Other
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Tuberculosis

If other has been selected above, Please explain:

PRE-MED patients: please list why Pre-Med is needed:

If there have been any medical changes since your last visit with us, please list below.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Response Date:

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

* ☐ By checking this box, I understand the above information and agree with its contents,

Response Date: _____

Twenty-First Century Dental, P.C

4001 Asbury Avenue Suite 1
Tinton Falls, NJ 07753
732-922-1060

2701 Bridge Avenue
Point Pleasant, NJ 08742
732-701-3540

Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of one year from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

Twenty-First Century Dental, P.C

4001 Asbury Avenue Suite 1
Tinton Falls, NJ 07753
732-922-1060

2701 Bridge Avenue
Point Pleasant, NJ 08742
732-701-3540

Consent for Internet Communications

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____