Klockner Road Office, 2929 Klockner Road, Hamilton Square, NJ 08690 (609) 586-6603
Kuser Road Office, NJ Family Care, 2501 Kuser Road (2nd Floor), Hamilton Township, NJ 08691 (609) 689-1212

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____ SSN: _____ Gender: ☐ M ☐ F

Marital Status: Single Married Separated Divorced Widowed

HEALTH INFORMATION

Date of Last Dental Exam: _____ X-rays Taken: ☐ Y ☐ N Reason for Visit: _____

Have you ever had any of the following? Please circle Yes or No.

ADD/ADHD	Y	N	Down Syndrome	Y	N	High Blood Pressure	Y	N	Radiation Treatment	Y	N
AIDS/HIV Positive	Y	N	Drug Addiction	Y	N	Hypoglycemia	Y	N	Respiratory Problems	Y	N
Allergies	Y	N	History of Endocarditis:			Jaundice	Y	N	Rheumatic Fever	Y	N
ANxiety/Panic	Y	N	(Heart Infection)	Y	N	Irregular Heartbeat	Y	N	Rheumatism	Y	N
Asthma	Y	N	Epilepsy or Seizures	Y	N	Joint Replacements:			Sinus Problems	Y	N
Autism	Y	N	Excessive Bleeding	Y	N	(Hip, Knee)	Y	N	Sjogren's Syndrome	Y	N
Blood Disease	Y	N	Fainting Bleeding	Y	N	Kidney Problems	Y	N	Stomach Problems	Y	N
Cancer	Y	N	Glaucoma	Y	N	Leukemia	Y	N	Stroke	Y	N
Chemotherapy	Y	N	Head Injuries	Y	N	Liver Disease	Y	N	Thyroid Disease	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Disease	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Congenital Heart Disorder	Y	N	Heart Murmur	Y	N	Mental Disorders	Y	N	Tumors or Growths	Y	N
Convulsions	Y	N	Hepatitis A	Y	N	Nervous Disorders	Y	N	Valve Replcements	Y	N
Developmentally Delayed	Y	N	Hepatitis B or C	Y	N	Pain in Jaw Joints	Y	N	Other	Y	N
Diabetes	Y	N	Herpes	Y	N	Pregnancy	Y	N			

If you answered yes, please explain: _____

Please list any serious illness not listed above: _____

Do you have any drug allergies? ☐ Y ☐ N If yes, please explain: _____

List any medication(s) you are currently taking: _____

Have you ever had any complications following dental treatment: ☐ Y ☐ N

If yes, please explain: _____

Have you ever had any of the following habits?

☐ Lip Sucking/Biting ☐ Nail Biting ☐ Nursing/Bottle Habits ☐ Thumb/Finger Sucking

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Y ☐ N

If yes, please explain: _____

Do you have any health problems that need further clarification? ☐ Y ☐ N

If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct.
If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date: _____

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ADULT CONTACT INFO

Date: _____ Account #: _____

Patient Name: _____
Last First MI

Date of Birth: _____ / _____ / _____ SSN#: _____ Gender: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Preferred method of contact: ☐ Cell ☐ Text ☐ Work

Place of Employment: _____ Occupation: _____

Work phone: _____ Email Address _____

Spouse Name: _____
Last First MI

Date of Birth: _____ / _____ / _____ SSN#: _____ Gender: ☐ M ☐ F

Place of Employment: _____ Occupation: _____

Work Phone: _____ Cell Phone: _____

Children in family:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name of Dental Insurance, If any: _____

Secondary Dental Insurance, If any: _____

Whom may we thank for referring you to our office? _____

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DENTAL AND MEDICAL INSURANCE INFORMATION

Today's Date: _____ / _____ / _____

Primary Dental Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Dental Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Dental Insurance Company Phone Number: ( ) _____-_____

Secondary Dental Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

I have been informed of the treatment plan and associates fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

*Sign*_____*Date:* _____/_____/_____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Hamilton Dental Associates.

*Sign:*_____*Date:* _____/_____/_____

Please bring your Dental and Medical Insurance cards with you on your visit

continued on next page...

Secondary Dental Insurance (continued)

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Dental Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Dental Insurance Company Phone Number: ( ) _____-_____

Primary Medical Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Medical Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Medical Insurance Company Phone Number: ( ) _____-_____

Secondary Medical Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Medical Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Medical Insurance Company Phone Number: ( ) _____-_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

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Financial Policies for Hamilton Dental Associates

Recently, we have seen continuous changes in the insurance plans of our patients. Managing insurance claims on behalf of our patients has become increasingly intricate in the current dental landscape of ever changing plans and benefits. *In order to serve you properly, it is essential that you provide us with the most detailed and updated information concerning your dental insurance(s). (For example, Aetna Insurance now has hundreds of different dental sub-plans, all with differing benefits.)*

Hamilton Dental Associates is not an agent of, nor is it associated with, any dental insurance company. The ultimate responsibility of determining and understanding the details, restrictions and limitations of your insurance is yours. As a courtesy to our patients, we currently are happy to provide the service of completing, submitting and receiving payments from your insurance company; however, **it is important that you understand that any pre-estimate, either determined by our office or by your insurance company is not a guarantee of payment. Further, these estimates are subject to changes made by your insurance company during claim processing**. Insurance benefits, used to create our office's estimates, are determined by many criteria including but not limited to, your eligibility at the time of treatment, any noted deductibles, and yearly or family maximums. **We cannot guarantee payment from an insurance carrier, nor be held responsible for multiple inquiries, requests or refusals made by insurance company(s) during claim processing. All fees for your treatment are your responsibility, not that of any insurance company or policy**. Unless payment arrangements have been made in advance, payment for services is expected at the time of treatment. Unpaid patient balances are subject to placement with a third party collection agency, and will incur a 25% collection processing fee.

For our patients with dental insurance, signing this form, in addition to understanding the above, gives our office permission to provide your insurance carrier with information from your dental records, which may assist in processing your claims. As part of the contract with your insurance carrier, patients also agree that insurance payments for dental services performed by Hamilton Dental Associates will be directly endorsed to our office. If, for any reason, insurance payments are issued to the patient directly, it becomes the patient responsibility to endorse these payments to the office where services were provided. If the amount owed to this office is less than the amount of the dental benefit payment, then the patient shall pay only the balance owed. Credits will be kept on accounts unless otherwise requested, in which case a refund can be issued within 30 days of request.

Finally, we appreciate and value the time of our patients. In recognition of fellow patients, who may have otherwise been able to attend an open appointment time slot, patients that miss multiple appointments without contacting our office may be assessed a $50 cancellation fee. I understand that I am financially responsible for all professional services rendered, and that a 25% collection fee will be assessed on all unpaid balances that are placed with our collection agency.

I understand that I am financially responsible for all professional services rendered, and that a 25% collection fee will be assessed on all unpaid balances that are placed with our collection agency.

PRINT Patient, Parent, Responsible Party SIGNATURE Date