1155 Route 72 West
Manahawkin, NJ 08050
609-978-7770

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____
Preferred Name (if different) _____

Birthday (mm/dd/yyyy): _____ Social Security #: _____
Marital Status: __ Married ___ Single ____ Widowed ___ Other
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-Mail: _____
Parent/Guardian/POA (if under 18): _____
DOB: _____ Social Security # _____

DENTAL INSURANCE INFORMATION

Dental Insurance (name): _____
Member/Subscriber ID# _____
Subscriber Name: _____
DOB: _____
Ins Phone Number: _____
Group Number (if it applies): _____

Secondary Dental Ins (name): _____
Member/Subscriber ID#_____
Subscriber Name: _____
DOB: _____
Ins Phone Number: _____
Group Number: _____

Emergency Contact: _____
Phone Number: _____

EMPLOYER INFORMATION

Employer Name: _____
Occupation: _____
Employer Address: _____
Employer Phone Number: _____

How did you hear about our office? _____

Patient Name: _____

MEDICAL HISTORY

Please mark all that apply

__Arthritis
__Glaucoma
__Artificial Joints
If Marked: Do you need to pre-medicate? ____
__Liver Disease
__Jaundice
__Hepatitis
Type: _____
__Blood Disease
__Anemia
__HIV/AIDS
__Tuberculosis
__Kidney Disease
__Thyroid Disturbance
__Diabetes
Type: _____
__Heart Disease
__Heart Attack
Year: _____
__Pregnant
If yes, due date? _____

__Heart Murmur
__Mitral Valve Prolapse
__Rheumatic Fever
__High Blood Pressure
__Cancer
Year: _____
__Radiation Treatment
Year: _____
__Chemotherapy
Year: _____
__Tumors
__Ulcers
__Gastric Reflux
__Stroke
Year: _____
__Anxiety
__Depression
__Sinus Problems
__Asthma

Do you smoke? __ Yes ___ No

Allergies:

__Penicillin
__Aspirin
__Codeine
__Novocain/EPI
Other: _____

Current Medications:
Please List: _____
Pharmacy Name: _____ City:_____ Phone: _____

Dental History:

Date of Last Cleaning/Check-Up: _____
What brings you here today? _____
Any problems you would like the doctor to address? _____

Are you interested in chair side whitening? _____ Yes _____ No
Are you interested in invisible aligners? _____ Yes _____ No

Seaview Dental

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Patient Name: _____

FINANCIAL POLICY

- All payments are due at time of service/appointment. We accept cash, check, Visa, Mastercard, American Express, Discover, and Care Credit
- You, the patient, is responsible for providing the office, if applicable, with your dental insurance information prior to your appointment.
- We are contracted with multiple dental insurance companies, for any other insurances we are not contracted with you, the patient, are financially responsible for all fees associated with your treatment.
- We do our best to give you an estimate of all fees associated with your insurance, this is only an estimate, you, the patient, are ultimately financially responsible for all costs associated with your treatment. We do recommend a pre-treatment on all costly procedures.
- All returned checks will receive a $25 returned check fee because the bank charges us.
- **I herby authorize Seaview Dental of Stafford to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Seaview Dental of Stafford. I understand I am responsible for any unpaid balance within 30 days of billing. Account is subject to a 1.5% monthly interest on account over 60 days. I agree that if my account is sent to an outside collection agency or attorney for collection, I will be responsible for any additional collection fees associated with the account. Initial_____**
- I have read the above financial policy and understand and agree to abide to its terms.

Patient/Parent/Guardian/POA Signature: _____ Date: _____

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HIPPA

- I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:
  - Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment
  - Obtaining payment from a third party (i.e., insurance companies, collection agencies)
  - The day-to-day healthcare operation of the practice
- I understand I can request a copy and review the notice of our *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and I may contact you to obtain the most recent copy.
- I understand I have the right to request restrictions on how my protected health information is used and disclosed prior to carrying out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.
- I, as the patient have the right to restrict certain disclosures of Protected Health Information to a health plan where I or my representative, pays out of pocket in full for the healthcare item or service. I also have the right to opt out of fundraising communications.
- I understand that I may revoke this consent at any time.

Our responsibilities as the practice:

- We will notify the below signed patient if there has been a breach of unsecured Protected Health Information
- We can transmit copies of Protected Health Information in an electronic form directly to an individual's designee, provided the choice is clear, conspicuous and specific.
- Authorization is required for: uses and disclosures of Protected Health Information for marketing purposes, disclosures that constitute a sale of Protected Health information; as well as any other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

I give permission for the doctor and staff to release information regarding my account, treatment, or any questions asked to the following person:

Name: _____Relationship: _____

Patient Signature: _____ Date: _____