Hillsborough Family Dental
Cheryl Vicari, DMD
www.HillsboroughFamilyDental.net
811 Courtyard Drive • Hillsborough, NJ 08844 • Phone 908.722.0321

PATIENT INFORMATION

Patient Full Name: ____ Patient's SSN: __________________

Date of Birth: ________________________ SEX: M __ F __ Marital Status: S __ M __ D __ W __

Street Address: ____ Apt. No.: __________________

City: ____ State ___________ Zip Code: ____________

Home phone: (_____) _____________________________Work phone: (_____) _____________________________

Cell Phone: (______) ___________________ Email Address: _____________________________________

Employer:________________________________Emergency Contact Name: ________________________________

Emergency Contact Phone: (______) _____________Relationship to patient:________________________________

Who can we thank for referring you? ____

How would you prefer us to send appointment reminders? (Circle one)

Cell Phone Home Phone Text Email

GUARANTOR/PARENT INFORMATION (If applicable)

Responsible Party Name: ______________________________________ ____________________ _____________
(Last) (First) (Middle)

Relationship to Patient: ______________________________ Responsible Party Date of Birth: __________________

Guarantor's Social Security Number: _______ - _____ - _________

Guarantor's Address: ____ Apt. No.: __________________

City: ____ State ___________ Zip Code: ____________

Home phone: (_____) _________________________ Cell phone: (______) _________________________

Employer's Name: ____

PATIENT'S INSURANCE INFORMATION

Please Provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: ____

Insurance Address: ____

City: ____ State ___________ Zip Code: ____________

Phone Number (____) ________________ Policy Holder's Social Security Number: _______ - _____ - _________

Name of Policy Holder: ____Date of Birth: _____________________

Insurance ID Number: ___________________________________ Group Number: ___________________________

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Secondary Insurance Company's Name: ____

Insurance Address: ____

City: ________________________________State ___________ Zip Code: ____________

Phone number (____) ______________

Name of Policy Holder: ____________________________Date of Birth: ________________

Insurance ID Number: _________________________ Group Number: ______________________

I hereby authorize my insurance benefits to be paid directly to Hillsborough Family Dental. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _________________________________ Date: _______________

IMPORTANT OFFICE POLICIES RELEASE OF MEDICAL INFORMATION

I have received the notice of privacy practices, and I have been provided an opportunity to review it.

I authorize Hillsborough Family Dental to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa, MasterCard and Discover. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non- covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

We value your time and set aside an allotted amount of time for you upon scheduling an appointment. Please arrive at your scheduled appointment time. If you are running late, please contact our office so we can plan accordingly. When you need to cancel, please let us know as soon as you can.

I give permission to the indicated name below to be able to discuss my dental treatment, account balance, or ask questions regarding my account and/or health records. *(Optional)*

Name: ______________________________ Relationship: ____________________

**This does not apply to children under 18 years of age*

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: ______________________________ Date: ____________________

PLEASE READ AND SIGN FORM

Dental History

Reason for today's visit ____________________

____

Former Dentist ____________________

City/State ____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ____________________

How often do you brush? ____________________

Health History

Physician's Name ______________________________ Date of last visit ____________________

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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type ________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ____________________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ____________________

Phone (______) ____________________

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other ____________________

____