**VERONA CEDAR GROVE DENTAL ASSOCIATES vcgdenatal@me.com**

**756 POMPTON AVE. CEDAR GROVE, NJ 07009 (973) 239-6969**

## Patient Registration Form

***Thank you for choosing our practice! We look forward to taking care of all your dental needs. Please fill out this form in ink only. If you have any questions regarding this form, do not hesitate to ask for assistance. We will be happy to help. PLEASE BRING COMPLETED FORM TO YOUR FIRST VISIT***

**(Please Print) Patient Name:_____**

**Date:_____ Birthdate:_____**

**SS#:_____**

**SEX: Male / Female (Marital Status: Single Married Divorced Widowed Partnered)**

**Spouse's Name:_____**

**Home Address:_____City/State/Zip:_____**

**Home Phone: _____ Work Phone_____**

***Cell Phone:_____ *Email:_____**

**<u>OUR OFFICE OPERATES THROUGH EMAIL AND TEXTING MODULES. CELL PHONE AND EMAIL REQUIRED IN ORDER TO ACTIVATE PATIENT ACCOUNT.</u>**

**If we have to speak with you, what is the best way to contact you? Home / Cell / Work**

**Work /Employer/ Occupation:_____**

**Address:_____**

**City/State/Zip:_____**

**Full Time Student (School)_____**

**Who may we thank for referring you?_____**

**RESPONSIBLE PARTY Name of person responsible for**

**Name:_____ Relationship:_____**

**Birthdate:_____ Age:_____ SS#:_____**

**Phone:_____**

**Address:_____**

**City/State/Zip:_____**

**Employer Name:_____**

**Work Phone:_____ *Please list an Emergency Contact not living with you**

**(Name/Phone):_____**

## PRIMARY DENTAL INSURANCE INFORMATION

**Subscriber's Name:_____**

**Relationship:_____ Birthdate:_____**

**SS#:_____ ID#:_____**

**Insurance Company:_____**

**Group #:_____ Insurance Phone#:_____**
**Insurance**

**Insurance Address:_____**

**Employer's Name:_____**

**Work Phone:_____**

## SECONDARY DENTAL INSURANCE INFORMATION

**Do you have secondary dental insurance? YES NO Subscriber's**

**Name:_____**

**Relationship:_____ Birthdate:_____**

**SS#:_____ ID#:_____**

**Insurance Company:_____**

**Group #:_____ Insurance Phone#:_____**

**Insurance Address:**_____

**Employer's Name:**_____

**Work Phone:**_____

## CONFIDENTIAL

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

**Date:**_____ **Former Dentist:**_____

**City:**_____ **State:**_____

**Phone:**_____ **May we contact them?** **YES** **NO**

**Why did you leave your previous dental office?**

_____

**What is the most important reason for your dental visit today?**

_____

**The most important thing about your future smile and dental health is:**_____

## DENTAL INFORMATION

**Please Share Some Dates:**

**Your Last Cleaning:**_____

**Your Last set of X-rays:**_____

**Your Last Dental Exam:**_____

**On a Scale of 1-10, with 10 being the highest rating:**

**How important is your dental health?**

**1 2 3 4 5 6 7 8 9 10**

**Where would you rate your *current* dental health?**

**1 2 3 4 5 6 7 8 9 10**

**Where do you *want* your dental health to be?**

**1 2 3 4 5 6 7 8 9 10**

**Circle if you have the following problems apply to you?**

**Sensitivity / (Hot/Cold/Sweets) / Headaches / Earaches / Neck pain /**

**Teeth or Fillings breaking / Bleeding / Swollen or Irritated gums**

**Food Collection Between Teeth / Jaw joint pain / Grinding, Clenching / Bad Breath**

**Loose, Tipped or Shifted teeth / Braces / Periodontal (gum) Treatment**

**Do you have/had any of the following? Dentures / Partials /Implants**

## MEDICAL INFORMATION

**Physician's Name:_____**

**Phone:_____ Last Exam:_____**

**Have you been hospitalized within the last 5 years? YES NO**

**If yes, reason:_____**

**For the following, please circle *yes or no* if applicable:**
**Your answers are for our records only and will be confidential.**

**Please note that during your initial visit you will be asked some questions about your responses.**

**Our staff may ask additional questions regarding your health.**

**Anemia or Blood Disorder NO YES**

**Hepatitis NO YES**

**Any Form Arthritis, Rheumatism or Inflammatory Disease NO YES**

**Artificial Joint Replacement NO YES If YES Where? _____**

**Name and Phone # for Surgeon_____**

**Asthma NO YES**

**Kidney Disease NO YES**

**Abnormal Bleeding NO YES**

**Liver Disease (including Jaundice) NO YES**

**Cancer or Tumor NO YES Chemotherapy NO YES**

**Sore/ Enlarged Lymph Nodes Diabetes NO YES**

**Psychiatric Care NO YES**

**Emphysema or other Respiratory/ Lung Illness NO YES**

**Previous Biopsies Epilepsy NO YES**

**Radiation or Chemotherapy Treatment NO YES**

**Fainting or Dizzy Spells Glaucoma NO YES**

**Slow- Healing Mouth Sores NO Yes**

**Unintentional Weight Gain or Loss NO YES**

**Venereal Disease NO YES**

**H.I.V Infection AIDS or ARC NO YES**

**Rheumatic Fever NO YES**

**Heart Disease, Heart Attack, Heart Surgery NO YES**

**Heart Valve (artificial) or Heart Transplant NO YES**

**Abnormal Heart/ Previous Bacterial Endocarditis NO YES**

**Heart Murmur NO YES**

**Mitral Valve Prolapse NO YES**

**Stroke NO YES**

**Tuberculosis NO YES**

**Heart Stent Placed NO YES If YES When?_____**

**Cardiac Surgeon_____**

**Nervous Problems NO YES**

**Mitral Valve Prolapse NO YES**

**Stroke NO YES**

**Persistent NO YES**

**Back Problems NO Yes**

**Swelling of Feet or Ankles NO YES**

**Abnormal Blood Pressure? NO YES**

**Have you ever received a diagnosis of "high blood pressure"?**
**Greater than 115/75 YES NO**

**If yes, are you under a doctor's care? NO YES**

**Thyroid Problems NO YES**

**If YES do you have LOW or HIGH Thyroid?**

**Women: Are you pregnant? YES NO**

**Is there any chance you might be pregnant? YES NO**

**Are you a nursing mother? YES NO**

**Are you taking birth control? YES NO**

**FOR WOMEN WHO HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE NOTIFY STAFF IN PERSON BEFORE ANY X-RAYS OR MEDICATION IS ADMINISTERED.**

## CONFIDENTIAL

**Name:**_____

**Age:**_____ **Date:**_____

**Are you taking or have you been treated with bisphoshonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? YES NO**

**If so, when did the treatment start:**_____

**Please list any medications, or dietary/herbal supplements you are currently taking and for what purpose:**

_____

_____

_____

**Do you Pre-Medicate before dental visits?**
**NO**
**YES IF YES WHY?**_____

**ARE YOU TAKING ANY OF THE FOLLOWING?**

***Bloodthinners (Coumadin, Warfarin)***
***NO***
***YES***

***IF YOU HAVE ANSWERED YES: A MEDICAL CLEARANCE IS MANDATORY PRIOR TO VISIT: PLEASE NOTIFY STAFF WHO WILL TAKE CARE OF THIS FOR YOU***

**Tagamet (Cimetidine) or Prilosec (Omeprazole)**
**NO**
**YES**

**Antacids?**
**NO**
**YES**

**Cardizem (Diltiazem) or Calan, Isoptin (Verapamil)**
**NO**
**YES**

**Diantin or Tegretol**
**NO**
**YES**

**Serzone (Nefazodone)**
**NO**
**YES**

**Barbiturates (any)**
**NO**
**YES**

**Diflucan (Fluconazole) or Sporonox (Itraconazole)**
**NO**
**YES**

**St. John's Wort or Kava-Kava**
**NO**
**YES**

**Biaxin (Clarithromycin)**
**NO**
**YES**

**Levoxl, Synthroid**
**NO**
**YES**

**Fen-Phen, Redux, Pondimin**
**NO**
**YES**

**Do you consume Grapefruits, juice, or extract**
**NO**
**YES**

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

**Local Anesthetics**
**NO**
**YES**

**Codeine, Valium or other sedatives**
**NO**
**YES**

**Penicillin or other antibiotics**
**NO**
**YES** **If Yes: specify name_____**

**Latex**
**NO**
**YES**

**Aspirin, Ibuprofen, Tylenol**
**NO**
**YES**

**Metals**
**NO**
**YES**

**Other (Please Specify)_____**

**Do you use any mood altering drugs other than those previously listed?**
**YES NO**

**Do you smoke? YES NO**

**IF YOU ARE LATEX SENSITIVE PLEASE ALSO VERBALLY NOTIFY STAFF**

## Certification and Assignment

**To the best of my knowledge the above information is complete and correct. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I certify that I and my dependant(s), have insurance coverage with _____and assign directly to Verona Cedar Grove Dental Associates/ Dr. Wayne J. Madsen & Dr. Beth Cacossa-Madsen all insurance 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 authorize the use of my signature on all insurance claims. The above-named doctor and facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I hereby authorize Verona Cedar Grove Dental Associates to take study models, X-rays, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Verona Cedar Grove Dental Associates to perform all forms of treatment, medication, and therapy that may be indicated; I also understand that the use of anesthetic agents embodies a certain risk.**

## Financial Policy

**By signing below you are stating you understand the following: Payment & all insurance Co-pays are due at the time services are rendered. Our office accepts cash, personal checks, MasterCard, Visa, American Express & Discover. Our office also offers outside financing upon request and approvals please ask for further details. As a courtesy to our insured patients, we will gladly file your dental claims for services rendered. Please understand that we are only given an estimate for your dental care therefore we can only pass the estimate on to you, the patient. After your insurance pays their portion, there may still be an amount due. This amount will be your responsibility and will be sent to you in the form of a statement. Please understand that we will do our best to get your insurance to pay for all work performed by our office, however most insurance plans only pay for a portion of dental services. Please understand that if after 60 days there has been no payment made it is your responsibility to follow up with your insurance and retain payment.**

**Signature:_____**
**Date:_____ Patient, Parent, Guardian,**
**Doctor's**
**Signature:_____Date:_____**

# HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Verona Cedar Grove Dental Associates 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 third party payers (e.g. insurance company)

- Day-to-day healthcare operations of the practice (email/ text reminders/ confirmations of appointments via online services)

I have also been informed of and aware of a copy of your Notice of Privacy Practices, at vcgdental.com for my review, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Verona Cedar Grove Dental reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Patient Name Printed:_____

Signature:_____