Riverfront DENTAL CARE

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***Welcome to Riverfront Dental Care,***

Our dental team is pleased to welcome you to our practice, and we thank you for selecting us to care for your dental needs. We pride ourselves on making dentistry a pleasant experience and look forward to meeting you.

On your first visit with us, we will listen carefully to your dental concerns and answer any questions you may have. You can expect a thorough oral examination and diagnosis including cancer screening, necessary x-rays, and a discussion of the most appropriate treatment to meet your oral health goals. We request payment for this visit at the time of the appointment.

Enclosed is some information about our practice, and forms requesting information we will need from you. Please complete these forms and return them to us in the enclosed envelope as soon as possible. That way, we can be better prepared for your arrival and ensure that we have adequate time to provide the care and attention you need.

We recognize the value of your time, and make it a priority to be on time for you. We have reserved an hour in the doctor's schedule exclusively for you. If for some reason you cannot keep your appointment, we ask that you give a cancellation courtesy of at least one full business day.

Thank you for choosing us as partners in your dental health. If you have any questions, please give us a call.

Cordially,
*Drs. Rella, Kazanjian, and Staff*

*P.S.* ***Please remember to:***

- ~ *Bring a photo identification to your appointment.*
- ~ *Complete and* ***return the patient forms ASAP.***
- ~ *Provide at least one full business days notice if you are unable to keep your appointment.*

***We have reserved an hour for your visit on _____/_____/_____ at _____***

# *RIVERFRONT DENTAL CARE*
## *WELCOMES YOU TO THEIR PRACTICE !*

***Please help us*** *by completing this form in ink. If you need assistance, please ask.* ***Thank You!***

### PATIENT INFORMATION

**legal name, last**_____ **first** _____ **middle** _____
( Dr. / Mr. / Mrs. / Ms. ) ( M / F ) [ ] minor [ ] single [ ] married
**preferred / nickname** _____ age _____ birth date _____/_____/_____
street _____ soc sec # _____-_____-_____
city _____ st _____ zip _____ home phone (_____)_____-_____
employer _____ phone (___)___-_____x_____ cell phone (_____)_____-_____
spouse _____ emerg contact _____ emerg phone (_____)_____-_____
***How did you learn of our office?*** _____ email addr _____

### BILLING INFORMATION *( if different from patient)*

**name** _____ birth date _____/_____/_____
( Dr. / Mr. / Mrs. / Ms. ) relationship _____ soc sec # _____-_____-_____
billing street _____
billing city _____ st _____ zip _____ pref. phone (_____)_____-_____
employer _____ work phone (_____)_____-_____x____

### DENTAL INSURANCE INFORMATION

**Primary:**
subscriber _____
relationship _____ birth date ___/___/___
employer _____
union _____ emplr ph# (____)____-_____
ins company _____
group# _____ s.s./id# _____

**Secondary:**
subscriber _____
relationship _____ birth date ___/___/___
employer _____
union _____ emplr ph# (____)____-_____
ins company _____
group# _____ s.s./id# _____

### AUTHORIZATON AND CONSENT

Please read and ***initial*** each of the following, and then ***sign*** below where indicated.

_____ I acknowledge that a minimum notice of one full business day per hour scheduled is required to change an appointment, otherwise, a cancellation fee of $50 per half hour scheduled may be charged.

_____ I request and consent to recommended dental services deemed appropriate by the dentist to be provided for me (and/or my dependent) for diagnosis and treatment, and that no guarantees have been made about the results of treatment.

_____ I authorize: The release of information relating to my dental care to third party payers and other health professionals; for this office to request a review and/or appeal of claim determinations from my carrier; for my insurance company to pay directly to the dentist benefits otherwise payable to me.

_____ I acknowledge: That my insurance is a contract between my carrier and me; that I am responsible for knowing the benefits and limitations of my policy; that insurance estimates are provided as a courtesy only; that my insurance may pay less than the actual bill for services or estimated insurance payment; and that I am responsible for payment of all services rendered on behalf of me (and/or my dependents).

_____ I acknowledge: That full payment is due at or before each appointment; that credit arrangements can be made prior to treatment through CareCredit / by G.E. Financial; that a 1.25%(15% APR) monthly fin./rebilling charge (min.$4.25) may apply to any balance on account after 30 days; that returned checks will incur a $25 fee; that failure to keep my account current will result in denial of additional dental services except for emergencies and where pre-payment is made.

_____ In case of default I acknowledge: That I end my patient/doctor relationship; that collection expenses may be added to my account; that my account may be reported to a credit bureau; and I consent to be contacted for collection purposes.

*I have read, understand, acknowledge, and agree to the above conditions of treatment and payment.*

***Signature*** *Date* / /
*(of responsible party if minor)*

# MEDICAL HISTORY

**Name** _____ **Birthdate** ____/____/_____

Medical Dr._____

Pharmacy Name _____ Pharmacy Ph#_____

**Medications:** Are you taking any medications – including non-prescription? ... ***Yes \ No***
*If yes, please list below or attach a list to this form.*

_____
_____
_____
_____
_____

**Pre-medicate:** Have you been told you need antibiotics *before* dental work? .....**Yes \ No**

**Allergies**: Are you allergic to, or had reactions to any of the following?
***Yes \ No*** – penicillin/antibiotics
***Yes \ No*** – novacaine/anesthetics
***Yes \ No*** - **Other** – *If yes, please list.* _____
_____

**Health Conditions**: Do you have, or have you had in the past, any of the following?

***Yes \ No*** – heart trouble
***Yes \ No*** – breathing trouble
***Yes \ No*** – kidney disease
***Yes \ No*** – hepatitis
***Yes \ No*** – cancer / leukemia
***Yes \ No*** – pacemaker/defibrillator
***Yes \ No*** – **heart valve surgery**
***Yes \ No*** – **joint replacement**
***Yes \ No*** – **High Blood Pressure**
***Yes \ No*** – head / neck / face pain
***Yes \ No*** – liver disease
***Yes \ No*** – diabetes
***Yes \ No*** – seizures/epilepsy
***Yes \ No*** – heart murmur/ MVP
***Yes \ No*** – drug / alcohol problem
***Yes \ No*** – smoke / chew tobacco
***Yes \ No*** –**Osteoporosis/Bisphosphates**
***Yes \ No*** – thyroid condition
***Yes \ No*** – STD, AIDS or HIV

For Woman Only: Are you...
***Yes \ No \ Maybe*** – pregnant?
***Yes \ No*** – breast feeding?
***Yes \ No*** – using birth control?

**Is there anything else we should know about your health?**..... ***Yes \ No***
*If yes, please explain.* _____
_____
_____

***By my signature below, I certify that the above information is complete and accurate.***

*Patient's / Guardian's*
*Signature X* _____ ***Date*** ____/____/_____

FOR OFFICE USE **** MEDICAL ALERTS **** Hyg/Asst: _____
*«MedAlerts»*

*Dentist's Signature* _____ *Date* ____/____/_____

# MEDICAL HISTORY

# DENTAL HISTORY

**Name** _____ **Birthdate** ____/____/_____

What is the reason for initial visit? _____

_____

Do you have a problem? _____

_____

How long since last dental visit? _____ Dental cleaning? _____

How often did you see the dentist/hygienist? _____

How often do you brush? _____ Floss?_____

Do you experience any of the following?

Yes / No - clench or grind your teeth
Yes / No - jaw clicks or pops
Yes / No - pain in muscles of face or around ears
Yes / No - frequent head, neck, or shoulder aches
Yes / No - teeth sensitive to: hot? / cold? / sweet? / pressure?
Yes / No - gums bleed or hurt
Yes / No - dry mouth
Yes / No - bad breath
Yes / No - get food caught in teeth
Yes / No - loose, shifted or chipped teeth
Yes / No - unhappy with appearance of your teeth

Have you had any of the following?

Yes / No - gum treatment or surgery
Yes / No - braces
Yes / No - problems with previous dental treatment
Yes / No - unpleasant dental experiences
If yes, please explain. _____
Yes / No - strong dislike of some aspect of dentistry
If yes, please explain. _____

How do your feel about your teeth in general? _____

_____

Do you have any questions or concerns? _____

_____

***By my signature below, I certify that the above information is complete and accurate.***

*Patient's / Guardian's*
*Signature X* _____ ***Date*** ____/____/_____

FOR OFFICE USE

*Dentist's Signature* _____ *Date* ____/____/_____

# DENTAL HISTORY

# RIVERFRONT DENTAL CARE

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, the undersigned, 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 barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

# RIVERFRONT DENTAL CARE

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

## PATIENT RIGHTS

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: *Jan M. Rella, D.M.D.*

Telephone: *732-349-1295* Fax: *732-3494053*

Address: *117 East Water Street, Toms River, NJ 08753*