

WESTFIELD ORAL SURGERY ASSOCIATES
320 Lenox Avenue · Westfield, New Jersey 07090

PATIENT REGISTRATION INFORMATION

Patient Name: _____ Date: _____
Last First M CIRCLE ONE: Mr. Mrs. Miss

Home Address: _____
No. Street City State Zip

Social Sec. No.: _____ Home Phone No.: _____ Birthdate: _____

Employer: _____ Work Phone No.: _____
No. Street City State Zip

Referred by: _____
Name No. Street City State Zip

What is the reason for today's visit? _____

In case of an emergency, who should be notified? _____
Name Phone No.

PRIMARY INSURANCE CIRCLE ONE: Dental or Medical

What is your relationship with the insured? CIRCLE ONE: Self Spouse Child Other

Insured Name, if different from patient name (Write SAME if same as patient's name)

Last First M Social Security No. Birthdate

Insured Address, if different from patient address (Write SAME if same as patient's address)

No. Street City State Zip

Insured Employer, if different from patient employer (Write SAME if same as patient's employer)

Employer Name No. Street City State Zip

Insurance Company Name: _____

No. Street City State Zip

Group No.: _____ Insurance Company Phone No.: _____

ID No.: _____

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PATIENT FINANCIAL NOTICE

Please be advised that Westfield Oral Surgery Associates does not represent any insurance company, nor is Westfield Oral Surgery Associates responsible for any determinations made by your insurance company.

Insurance policies are agreements between the patient and the insurance carrier. It is the patient's responsibility to understand their policies and guidelines as to covered or non covered procedures.

The patient is responsible for all deductibles, co-payments at the time of treatment visit. If co-payments are not made at the time of treatment visit, this voids contract with your insurance carrier, and you may be responsible for the entire bill of office's usual and customary rates. If you are not prepared to pay the co-payment at the time of treatment visit, please advise the front desk.

Otherwise, I understand office policy noted above, as it pertains to my insurance, guidelines, and rules.

Signature _____ **Date** _____

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DENTAL HISTORY

Name	Address	City/State/Zip	Phone
Date of last dental visit _____		Date of last dental X-rays _____	

Dentist's Name _____

Please circle yes or no if you have had any of the following:

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

Please circle yes or no to indicate if you have had any of the following:

AIDS	Yes	No	Jaundice	Yes	No
Anemia	Yes	No	Jaw Pain	Yes	No
Arthritis, Rheumatism	Yes	No	Kidney Disease	Yes	No
Artificial Heart Valves	Yes	No	Liver Disease	Yes	No
Artificial Joints	Yes	No	Low Blood Pressure	Yes	No
Asthma	Yes	No	Mitral Valve Prolapse	Yes	No
Back Problems	Yes	No	Nervous Problem	Yes	No
Bleeding abnormally with extractions or surgery	Yes	No	Pacemaker	Yes	No
Blood Disease	Yes	No	Women:		
Cancer	Yes	No	Are you pregnant?	Yes	No
Chemical Dependency	Yes	No	Due date _____		
Chemotherapy	Yes	No	Are you nursing?	Yes	No
Circulatory Problems	Yes	No	Psychiatric Care	Yes	No
Congenital Treatments	Yes	No	Radiation Treatment	Yes	No
Cortisone Treatments	Yes	No	Respiratory Disease	Yes	No
Cough, persistent or bloody	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Scarlet Fever	Yes	No
Emphysema	Yes	No	Shortness of Breath	Yes	No
Do you wear contact lenses?	Yes	No	Sinus Trouble	Yes	No
Epilepsy	Yes	No	Skin Rash	Yes	No
Fainting or dizziness	Yes	No	Special Diet	Yes	No
Glaucoma	Yes	No	Stroke	Yes	No
Headaches	Yes	No	Swelling of Feet or Ankles	Yes	No
Heart Murmur	Yes	No	Swollen Neck Glands	Yes	No
Heart Problems	Yes	No	Thyroid Problems	Yes	No
Hepatitis	Yes	No	Tonsils	Yes	No
Type _____			Tuberculosis	Yes	No
Herpes	Yes	No	Tumor or growth on head or neck	Yes	No
High Blood Pressure	Yes	No	Ulcer	Yes	No
HIV Positive	Yes	No	Venereal Disease	Yes	No
			Weight Loss, Unexplained	Yes	No

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Medications

List medications you are currently taking:

Allergies

List any allergies:

Pharmacy Name and Phone No.: _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? **Yes** **No**

For what conditions? _____

Are you taking any new medications? **Yes** **No** If yes, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? **Yes** **No**

For what conditions? _____

Are you taking any new medications? **Yes** **No** If yes, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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FINANCIAL AGREEMENT

Please read the following and sign in the appropriate locations. If you have any questions whatsoever with regard to this agreement, please inquire at the front desk.

A. I _____, the undersigned, have insurance with _____ (insurance company,) and assign directly to Dr. Philip R. Geron or Westfield Oral Surgery Associates, all benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Deductibles or co-payments, if applicable, must be made at time of service.

Signature _____ Date _____

B. **Financial Agreement.** I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance plans. Estimated fees for service will be provided upon request after examination. If for some unusual reason, payment cannot be made in full at the time of service, any fees still not paid within 30 days of service will be billed at 1.5 percent monthly interest, and all legal/collection costs will be the patient's/guardian's responsibility.

Signature _____ Date _____

C. **Minor/Child Consent.** I, _____ (parent/guardian), being the parent of _____ (child's name), do hereby request and authorize the staff to perform necessary services for my child, including, but not limited to, examination, X-rays, administration of appropriate anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature _____ Date _____

If alternate financial agreement has been made, this will be documented on this financial agreement plan, as noted above.

**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 barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)