Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____
Social Security#_____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S
Address: _____
Street Apartment #
_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Please list any medications you currently take: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID.#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Donald C. Thiel, Jr., DMD, PA
3100 Princeton Pike, Suite 1-H
Lawrenceville, NJ 08648
609-882-9088

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in covered services. It is your responsibility to become familiar with your policy exclusions, deductibles, and required co-payments.

OUR COURTESY SERVICE TO YOU INCLUDES:

- Filing your insurance within 24 hours of your visit and requesting payment of your benefit to us.
- Electronically filing your insurance for short turnaround.
- Researching your dental insurance plan to advise you of benefits available to you. Putting the researched information into our Dentrix computer software, which calculates your co-payment for the services you receive. When we receive payment from the insurance company we are able to input the exact dollar amount for each service we have billed. Therefore, your co-payment, which is expected from you at each visit, should be as accurate as possible.
- Re-filing your insurance claim a second time within 30 days if it has not been paid.
- Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

- Payment of fees NOT covered by your insurance plan at the time the service is rendered.
- Understanding that the insurance policy belongs to you and we have no leverage to obtain payment form your insurance carrier.
- Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (UCR-Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
- Taking responsibility for payment if the insurance company does not pay our office within 45 days.
- Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign below and have your insurance card ready for us to copy for our file.

I hereby authorize Donald C. Thiel, DMD, PA. to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Donald C. Thiel, Jr. DMD, PA. I understand I am responsible for any unpaid balance.

_____ _____

Signature of Patient Date

Donald C. Thiel, Jr., D.M.D., P.A.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

Donald C. Thiel, Jr., D.M.D., P.A.

Leaving Messages on Voice Mail, Answering Machines or Family Members

At our office, we understand that communication is an important part of the patient/dentist relationship. So that we can get important information to our patients in a timely manner, we often leave messages on voice mail, answering machines or with family members.

Please provide the telephone numbers where we may contact you:

_____ _____ _____
(Home) (Work) (Mobile)

Detailed Voice Mail and Answering Machine Messages

In some cases, we may need to leave voice mail or answering machine messages with detailed information about your condition or treatment (such as the results of x-rays or scheduling of procedures). You should be aware that other individuals who have access to your voice mail or answering machine may hear these messages. At home this may mean that members of your family may hear these messages. At work it may mean that your employer may hear these messages.

Please tell us at which numbers we <u>may</u> leave <u>detailed</u> voice mail messages:

☐ Home ☐ Work ☐ Mobile

☐ None, do not leave detailed messages on my voice mail or answering machine.

Messages with Family Members or Other Who Answer Your Home Phone

We may also need to leave messages with detailed information about your condition or treatments such as results of x-rays or the scheduling of procedures, with family members, or others who answer your home telephone.

Please let us know if we may leave <u>detailed</u> messages with individuals who answer your home telephone, please indicate below:

☐ Yes, you may leave detailed messages with anyone who answers my home phone.

☐ No, please do not leave a detailed message with anyone who answers my home phone.

Patient Name_____
Patient Signature_____ Date_____

Donald C. Thiel, Jr., D.M.D., P.A.
3100 Princeton Pike
Building 1, Suite H
Lawrenceville, NJ 08648
(609)882-9088
FAX (609)882-5438

January 1, 2004

Dear Patients:

Due to our office's waiting list for both new and follow up office visits, effective January 1, 2004, the office has established a cancellation fee. The fee will be $50.00 for appointments that are missed or cancelled without 24 hours notice.

We ask that you please provide our office with a minimum of 24 hours notice avoid unnecessary fees to your account.

Thank you in advance for your cooperation.

Print Patient's Name_____

Patient's Signature _____
Or Legal Guardian

Date_____

Dr. Donald C. Thiel, Jr. D.M.D.,P.A.
Family Dentistry

XRAY POLICY

At Dr. Donald C. Thiel, Jr., Family Dentistry, your dental health is our priority. To make an appropriate dental diagnosis, adequate x-rays must be taken of your teeth and surrounding structures. We adhere to the following protocol to maintain quality of care:

All new patient comprehensive exams will consist of a Panoramic x-ray and a minimum of 4 Bitewing x-rays (2 on small children).

If you have multiple dental restorations, periodontal disease, or any number of diseased or affected areas, you will require a Full Mouth Series (FMX) of x-rays. An FMX, consisting of 18 films, provides greater detail of the teeth, their roots, and the surrounding boney structures. If you require an FMX, you will be credited for the Bitewings, as they are part of the FMX.

Please note that if an FMX is required, the series must be taken in order to continue treatment with us, regardless of your insurance coverage. It is a violation of state law to treat a patient without adequate x-rays. State law also dictates that a patient cannot consent to negligent treatment. Therefore, refusal of necessary x-rays will constitute termination of the doctor-patient relationship.

We appreciate your understanding of this policy. Staff members will be happy to answer any questions you may have.

_____

Signature Date