



# Personal Information Form

Dental Care Hillsborough  
706 US Highway 206  
Hillsborough, NJ 08844  
Phone: (908) 533.9027  
Dentist@DentalCareHillsborough.com  
DentalCareHillsborough.com

Date: \_\_\_\_\_

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ How do you prefer to be addressed: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  Single  Married  Widow  Separated  Divorced SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If Student, name of School/College:  PT  FT \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you first hear about our office: \_\_\_\_\_

Do we have your permission to send you occasional correspondence on informative dental topics as well as reminders of your appointments via email? You may opt out at any time.  Yes  No

*If the person responsible for this payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Insurance Information"*

Name of Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  Single  Married  Widow  Separated  Divorced SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Insurance Information

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Name of Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Address: \_\_\_\_\_

## Secondary Insurance Information

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Name of Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Address: \_\_\_\_\_

I certify that all of the information (including medical, personal, and insurance records) is true and complete. I understand that Dental Care Hillsborough will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I have read and agree to your HIPAA Notice of Privacy Practices on page 3.

If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Signature of Patient (Responsible Party if a minor): \_\_\_\_\_ **Please sign the form when you come into our office**

## Family Member Information

Please list the names of your spouse and children	Is person a patient		Sex M   F	Age	Date of Birth (mm/dd/yyyy)		Is person a patient		Sex M   F	Age	Date of Birth (mm/dd/yyyy)
	Yes	No					Yes	No			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Medical and Dental Health History Form

Medical Doctor's Name: \_\_\_\_\_ Doctor's Phone #: \_\_\_\_\_ Date of last completed physical: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you taking any medication, vitamins or supplements?  Yes  No

If yes, please list: \_\_\_\_\_

For what purpose? \_\_\_\_\_

Are you pregnant?  Yes  No If yes, how many months: \_\_\_\_\_

Rate your medical health:  Excellent  Good  Fair  Poor

Are you allergic or react to:  Penicillin  Codeine  Local injected Anesthetic  Latex  Other \_\_\_\_\_

Do you have:  a heart murmur  a heart condition  diabetes  joint replacements  implants

Have you ever been told that because of this that you need to take antibiotics prior to dental cleanings or other treatment?  Yes  No

Do you have or have you ever had any of the following

- |                      |  |                                    |  |                       |  |
|----------------------|--|------------------------------------|--|-----------------------|--|
| Arthritis            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes or HPV                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma or hay fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Malignancies         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Persistent cough                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aids, HIV positive                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice/Hepatitis    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged Bleeding                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Narrow Angle Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus trouble        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care, nervous problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Stroke   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      |  |                                    |  | Osteoporosis          | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please describe any current treatment, impending operation, or any other medical or dental condition that you have. \_\_\_\_\_

### General Dental Health and Concerns

What's most important to you about your teeth? \_\_\_\_\_

How would you rate your dental health?  Excellent  Good  Fair  Poor

What is the main barrier to your dental health being better?  Fear  Time  Costs  Other \_\_\_\_\_

Is keeping your teeth important to you?  Yes  No If yes, why? \_\_\_\_\_

Does having dental work make you feel anxious, nervous, or fearful?  Yes  No

How can we help you with any issues? \_\_\_\_\_

Do you have any:  Discomfort in teeth or mouth  Bleeding gums  Bad breath  Food traps around teeth

Which issues are most important to you in making dental health decisions:

- |  |   |
|--|---|
| <input type="checkbox"/> Convenient appointment times                                  | <input type="checkbox"/> Dealing with anxiety associated with dental care |
| <input type="checkbox"/> Comfort aids such as, headphones, TV's, Nitrous Oxide         | <input type="checkbox"/> Quality care and materials                       |
| <input type="checkbox"/> Detailed treatment explanations and a chance to ask questions | <input type="checkbox"/> Using your dental insurance                      |
| <input type="checkbox"/> Dental Specialist in site                                     | <input type="checkbox"/> Availability of sedation for dental work         |

### Dental Appearance

How would you rate the appearance of your smile from 1 - 10 ? \_\_\_\_\_

If you could make any changes about your dental appearance what would be important to you:

- |   |   |
|---|---|
| <input type="checkbox"/> Whiten Teeth                         | <input type="checkbox"/> Replace discolored or old looking crowns   |
| <input type="checkbox"/> Create a more youthful looking smile | <input type="checkbox"/> Repair worn, chipped or broken teeth       |
| <input type="checkbox"/> Replacing missing teeth              | <input type="checkbox"/> Remove silver fillings for health reasons  |
| <input type="checkbox"/> Close spaces between teeth           | <input type="checkbox"/> Straighten teeth with braces or Invisalign |

### Head, Neck or Facial Pain

Do you ever get:

- Stress headaches  Migraines  Ear pain  T M Joint pain  Sensitive teeth  Clicking in Jaw Joints  Hard to chew or pain with chewing

Do you ever need to take any drugs or medicines to relieve the pain? \_\_\_\_\_

Have you consulted with any doctors about these issues? \_\_\_\_\_

After completing the forms, please either:

- a) **Submit securely directly to our office** or b) **Print and bring the forms to our office**

# Dental Care Hillsborough

## **HIPAA Notice of Privacy Practices**

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**THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW IT CAREFULLY.**

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This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (such as Family members, etc.). We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your healthcare and/or with payment for your healthcare.

For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. An another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. Some sessions with our treatment coordinators, doctors, hygienists or any other staff members may be recorded for quality and training purposes. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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### **Your rights:**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information:** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communication from us by an alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i. e. electronically.

**You may have the right to have your physician/dentist amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. We will not retaliate against you for filing a complaint.

This notice was published and was placed in effect on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (908-533-9027).