WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑Y ❑N Bad breath	❑Y ❑N Food collection between teeth	❑Y ❑N Periodontal treatment	❑Y ❑N Sensitivity to sweets
❑Y ❑N Bleeding gums	❑Y ❑N Grinding or clenching teeth	❑Y ❑N Sensitivity to cold	❑Y ❑N Sensitivity when biting
❑Y ❑N Clicking or popping jaw	❑Y ❑N Loose teeth or broken fillings	❑Y ❑N Sensitivity to hot	❑Y ❑N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑Y ❑N

If yes, describe _____

Are you currently under physician care? ❑Y ❑N If yes, describe _____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑Y ❑N

Women: Are you pregnant? ❑Y ❑N Nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N

Check (✓) yes or no whether you have had any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy
❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments

❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis
❑Y ❑N High blood pressure

❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies (**latex**, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problems
❑Y ❑N Pacemaker/ Heart surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain or loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease
❑Y ❑N Rheumatic/Scarlet fever

❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status,I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Dental Claim Form

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Speciality (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization#
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other _____
18. Employer/School Name _____ Address _____

SUBSCRIBER/EMPLOYEE

19. Subs./Emp. ID# SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentists or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X _____ Signed (Patient/Guardian) DATE (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32-37) ☐Yes: ☐Dental or ☐Medical | 32. Policy#
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name _____ Address _____
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name _____ Address _____
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/subscriber) DATE (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: LORI MESSING, D.D.S. | 43. Phone Number: (732) 679-0008 | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.: 22-3181364
46. Address: 3 GRACE DRIVE | 47. Dentist License #: DI 16343 | 48. First visit date of current series: | 49. Place of treatment: X Office ☐Hosp. ☐ECF ☐Other
50. City: OLD BRIDGE | 51. State: NJ | 52. Zip Code: 08857 | 53. Radiographs or models enclosed? ☐Yes, How many? ____ ☐No | 54. Is treatment for orthodontics? ☐Yes X No — If service already commenced: Date appliances placed / Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: / Date of prior placement:
56. Is treatment result of occupational illness or injury? X No ☐Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? X neither — Brief description and dates

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans - List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty.	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent									Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X _____ Signed (Treating Dentist) License # 16343 Date (MM/DD/YYYY)

63. Address where treatment was performed: 3 Grace Drive
64. City: Old Bridge | 65. State: NJ | 66. Zip Code: 08857

Lori B. Messing D. D. S.
Gentle Dental Care

Cosmetic and General Dentistry
3 GRACE DRIVE OLD BRIDGE NJ 08857 732 - 679 - 0008

Payment Policy for Patients with Dental Insurance

It is our office policy to bill your insurance carrier as a courtesy to you; although you are ultimately responsible for the entire bill. Once the work is preauthorized, we will set aside that portion of the balance estimated to be paid by your insurance carrier.
We require that your estimated share be paid **before** all dental work is completed. If your insurance carrier does not remit payment within six weeks of treatment, the balance will be due in full from you. A finance charge of $5.00 per month will be added to any unpaid balance.

Please keep in mind that the amount you will be paying at the time of treatment may not represent your full payment. All claims must be processed thru your insurance company for finalization.

Since we are not a party to the agreement with your carrier, **it is not our policy to contact carriers to establish why they have not paid or why they have paid less than originally indicated**. If any payment is subsequently made by your carrier in excess of the balance we estimated, we will promptly refund the credit amount to you.

Several insurance companies are no longer returning x-rays which we would send them for predetermination of benefits. They will be destroying them. If you have such an insurance company, we will no longer be able to provide you with those x-rays for any reason as we will not have them.

_____
Date

_____
Patient Signature or Signature of Parent / Guardian

Lori B. Messing, D.D.S.

3 Grace Drive
Old Bridge, N.J. 08857
732-679-0008
Fax# 732-679-0067
LBMDDS87@gmail.com

It is the personal responsibility of the patient (or patient's guardian) for payment in full for all dental services rendered. If there is a failure to pay your balance due within 30 days of completion of treatment, you will be responsible for all fees, interest, attorney fees as well as costs of collection.

All payments must be paid and cleared prior to the completion of treatment or insertion of any crowns or bridges. Therefore, a check will not be acceptable at your final appointment. However, you may pay the balance due by check in advance of your final appointment. For your convenience, we also accept Mastercard, Visa as well as Care Credit.

We require a photocopy of your driver's licence and any dental insurance cards at your initial appointment.

Sincerely,

Lori Messing D.D.S.

Lori Messing, D.D.S.

Patient's Signature and Date

Lori B. Messing, D.D.S.
Cosmetic and General Dentistry

Gentle Dental Care

3 GRACE DRIVE OLD BRIDGE, NJ 08857

732-679-0008

WE NEED YOUR HELP AND UNDERSTANDING

Last-minute cancellations and no-show appointments are a concern. We have set specific time aside to perform **your** necessary dental treatment.

We would like to point out that it is customary and required that we receive notice of a change in plans at least **48 hours** in advance. In case of a personal emergency, please call our office as soon as possible. You may leave a message with the answering service if you call during non-business hours. This gives your dental office the opportunity to schedule another patient who needs to be treated. We are sure you understand policies must be set and adhered to and ask you to remember this: your broken appointment hurts three---you, another patient, and our office.

We will greatly appreciate your help in solving this problem. Thank you!

PLEASE NOTE: OUR ESTABLISHED POLICY REQUIRES THE PAYMENT OF $25.00 PER 1/2 HOUR FOR BROKEN APPOINTMENTS.

PLEASE AVOID THIS ADDITIONAL EXPENSE
BY GIVING US 48 HOURS NOTICE.

Patient's Name (please print):_____

Patient's Signature:_____Date:_____

Lori B. Messing, D.D.S.

Cosmetic and General Dentistry

3 Grace Drive, Old Bridge, NJ 08857

732-679-0008 – Fax 732-679-0067

www.lorimessingdds.com

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	◦ You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. ◦ We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. ◦ We may say no to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	◦ You can ask us to contact you in a specific way (for example, home, office or cell phone) or to send mail to a different address. ◦ We will say yes to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say no if it would affect your care. ◦ If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.
Get a list of those whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. ◦ We will include all the disclosures for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	◦ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ◦ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated.	• You can complain if you feel we have violated your rights by contacting our Privacy Officer at 2 Industrial Way West, Eatontown, NJ 07724 OR (732) 542-4477 ◦ You can file a complaint with DHHS Office of Civil Rights. Visit www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	◦ Share information with your family, close friends, or others involved in your care. ◦ Share information in a disaster relief situation. ◦ Include your information in a hospital directory. ◦ Contact you for fundraising efforts. *If you are not able to tell us your preference (for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we never share your information unless you give us written permission	• Marketing purposes. • Sale of your information. • Most sharing of psychotherapy notes.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example*: A doctor treating you for an injury asks another doctor about your overall health condition.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example*: We give information about you to your health insurance plan so it will pay for your services.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example*: We use health information about you to manage your treatment and services.

OTHER USES & DISCLOSURES

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our website.

Effective April 14, 2003 – Revised September 23, 2013

Lori B. Messing, D.D.S.

Cosmetic and General Dentistry

3 Grace Drive, Old Bridge, NJ 08857

732-679-0008 – Fax 732-679-0067

www.lorimessingdds.com

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print name of patient: _____ Date: _____

Signature of patient: _____ SSN: _____

For personal representative of the patient (if applicable):

Print name of personal representative: _____ Date: _____

Signature of personal representative: _____ Relationship to patient: _____

For practice use only:

Signature of practice Employee: _____ Date: _____

The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions. Please provide the following information:

Appointment Reminders/ Test Results (laboratory, x-rays, etc.):
If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all items below that apply to you.

May we call to remind you of an appointment or regarding test results? ☐ Yes ☐ No

Please call me at the following number(s):

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

If we get an answering machine/voicemail, may we leave a message? ☐ Yes ☐ No

If we get a family member, may we leave a message? ☐ Yes ☐ No

Policy for discussing your medical information with family members:
Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

☐ Spouse _____

☐ Parent(s) _____

☐ Child(ren) _____

☐ Sibling(s) _____

☐ Other(s) _____