Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Male: _____ Female: _____ Married: _____ Single: _____ Child: _____ Other: _____

Social Security #: _____ Birth Date: _____

Phone #'s: Home _____ Work _____ Ext _____

Cell _____ E mail _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐T ☐F

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Dental/Medical Office ☐ Yellow Pages
☐ Other _____

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

Financial Responsibility Information

Name: _____ Relationship to patient: _____

Social Security #: _____ Birth Date: _____

Phone#'s: Home _____ Work _____ Cell _____

Address: _____
Street Apartment #

_____
City State Zip Code

Signature of Responsible Party : _____

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 : _____

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: _____

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

Insurance Plan Name and Address: _____

_____

Kenneth F. Diana, DDS
419 Nassau Street
Brick, NJ 07823

Responsible Party/Family Name:_____

ACKNOWLEDGEMENT-NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to make available to you our **Notice of Privacy Practices**, and your rights concerning your health information. Accordingly, our **Notice of Privacy Practices** is posted in our reception area. This Notice takes effect 04/14/2003.
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. Any future changes in our **Notice of Privacy Practices**, will be posted promptly.
You may request a copy of our complete Notice at any time.
You may also decline to sign this acknowledgement. In this case, please notify the front desk receptionist.

I hereby acknowledge my review of the posted **Notice of Privacy Practices** for the office of Kenneth F. Diana, DDS

_____ _____
Signature of Responsible Party or Guardian Date

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT

I hereby authorize Kenneth F. Diana, DDS to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits.

_____ _____
Signature of Responsible Party or Guardian Date

I hereby authorize payment of dental benefits otherwise payable to me directly to Kenneth F. Diana, DDS. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

_____ _____
Signature of Responsibility Party or Guardian Date

MEDICAL INFORMATION

PATIENT NAME: _____ **DATE**_____

YES NO

____ ____ **Are you now under the care of a physician?**
Physician's name: _____ **Phone:** _____
Date of last medical exam: _____
Pharmacy name: _____**Phone:**_____

____ ____ **Are you now taking any medications or drugs?**
If yes, please list: _____
_____

____ ____ **Are you sensitive or allergic to any medications or anesthetics?**
(novocaine, penicillin, sulfa, codeine, etc)
If yes, please list: _____

____ ____ **Have you ever been told that you need to premedicate before dental treatment?**
If yes, please note medication prescribed: _____

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING?

____ ____ **AID/HIV positive**
____ ____ **Anemia**
____ ____ **Arthritis**
____ ____ **Artificial Joints (hips, knees, etc)...Date of surgery:** _____
____ ____ **Asthma**
____ ____ **Blood Disease**
____ ____ **Bulimia**
____ ____ **Cancer**
____ ____ **Cold Sores/Fever Blisters**
____ ____ **Diabetes**
____ ____ **Emphysema**
____ ____ **Epilepsy**
____ ____ **Excessive Bleeding**
____ ____ **Fainting**
____ ____ **Glaucoma**
____ ____ **Growths/Tumors**
____ ____ **Heart Disease or Attack**
____ ____ **Heart Murmur/Mitral Valve Prolapsed**
____ ____ **Heart Pacemaker....Date of surgery:** _____
____ ____ **Heart Surgery....Date of surgery:** _____
____ ____ **Hepatitis/Jaundice**
If yes, please indicate A (infectious), B (serum), or C: _____
____ ____ **High Blood Pressure**
____ ____ **Kidney Disease**
____ ____ **Latex Allergy**
____ ____ **Liver Disease**
____ ____ **Night Sweats with Weight Loss or Cough**

PLEASE TURN PAGE OVER AND CONTINUE

MEDICAL INFORMATION (continued)

YES	NO	
____	____	Pregnancy...Due date: _____
____	____	Radiation Treatment
____	____	Respiratory Problems
____	____	Rheumatic Fever
____	____	Sexually Transmitted Disease
____	____	Stomach/Intestinal Disease
____	____	Stroke
____	____	Thyroid
____	____	Tuberculosis
____	____	Are you on a diet at this time?
____	____	Do you have any diseases, conditions or problems not listed that you think we Should know about? Explain: _____
____	____	Do you have pain in or near your ears?
____	____	Do you habitually clench or grind your teeth during the night or day?
____	____	Do you have inflamed areas in or around your mouth?
____	____	Have you experienced any growth or sore spots in your mouth?
____	____	Do your gums bleed?
____	____	Any difficult extractions in the past?
____	____	Prolonged bleeding following extractions in the past?
____	____	Have you had instruction on the correct way to brush your teeth?
____	____	Have you ever had a full series of x-rays taken? If yes, please give the date: _____
____	____	Are any teeth sensitive to pressure, hot or cold?
____	____	Do you have any other specific dental complaints now? If yes, please explain: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____

Signature of Patient or Guardian **Date**

MEDICAL HISTORY UPDATE

Date	Comments	Signature