OHANA DENTAL
OF BERGEN COUNTY

30 Prospect Street

Midland Park, NJ 07432

PATIENT INFORMATION

Title: □ Mr. □ Mrs. □ Ms. □ Dr.		Today's Date:	
First Name:		Last Name:	
Birth Date:		SSN:	
Address:	City:	State:	Zip:
Home #:	Cell #:	Email:	
Patient Employed By:		Occupation:	
Business Address:		Business Phone:	
Whom may we thank for referring you:			
In case of emergency, who should be notified?			

INSURANCE INFORMATION

Person Responsible for Account:			
Relation to Patient:	Birthdate	SSN:	
Address (if different from patient's)		Phone:	
City:	State:	Zip:	
Person Responsible Employed by:		Occupation:	
Business Address:		Business Phone:	
Insurance Company:	Subscriber ID:	Group #:	

ADDITIONAL INSURANCE

Is patient covered by additional insurance: □ YES □ NO			
Subscriber Name:		Relation to Patient:	Birth Date:
Subscriber Employed by:		Business Phone:	
Insurance Company:		SSN:	
Subscriber ID:		Group #	

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to Ohana Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that 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 insurance submission.

_____

Responsible Party Signature | Relationship: | Date:

_____

Doctor's Signature | Date:

DENTAL HEALTH HISTORY

(CONFIDENTIAL)

DENTAL HISTORY

Reason for Today's Visit:

Former Dentist:

Address:

Date of last dental care: Date of last dental X-Ray:

Check ( ) if you have had problems with any of the following:

□ Toothache □ Grinding / clenching teeth □ Snoring □ Gums swollen, tender or bleeding □ Sensitivity to Epinephrine
□ Dry mouth □ Clicking or popping jaw □ Periodontal treatment □ Sensitivity when biting □ Loose teeth or broken fillings
□ Food collection between teeth □ Growth / sore spots in your mouth □ Sensitivity to pressure or irritants (cold, heat, sweets)

Are you happy with the appearance of your teeth? □ YES □ NO If not, Explain: _____

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name: Date of last visit:

Have you had any serious illnesses or operations? If yes, please describe:

Have you ever taken Osteoporosis (low bone density) medications／bisphosphonates? □ YES □ NO

Have you been told by your physician that you need to premedicate before a dental procedure? If yes, please explain:

WOMEN: Are you pregnant? □ YES □ NO ∗ Nursing: □ YES □ NO ∗ Taking birth control pills: □ YES □ NO

Check( ) if you have or have had any of the following:

□ AIDS	□ Circulatory Problems	□ Respiratory Disease	□ Tonsillitis	□ Tuberculosis
□ Arthritis,Rheumatism	□ Cough,Persistent	□ Hepatitis	□ Scarlet Fever	□ Chemotherapy
□ Artificial Heart Valves	□ Cough up Blood	□ High Blood Pressure	□ Shortness of Breath	□ Ulcer
□CortisoneTreatments	□ Anemia	□ Stroke	□ Diabetes	□ Heart Problems
□ Skin Rash	□ Hemophilia	□ Rheumatic Fever	□ Artificial Joint	□Kidney Disease
□ Asthma	□ Dialysis	□ Jaw Pain	□ Back Problem	
□ Swelling of Feet or Ankle	□ HIV Positive	□ Epilepsy	□ Thyroid Problems	
□ Blood Disease	□ Fainting	□ Liver Disease	□ Blood Transfusion	
□Tobacco Habit	□ Glaucoma	□ Nervous Problems	□ Psychiatric Care	
□ Cancer	□ Headaches	□ Pacemaker	□ Radiation Treatment	

□ Chemical Dependency Describe:_____

MEDICATION

List medications you are currently taking:

ALLERGIES

□ Aspirin □ Penicillin □Local Anesthetic
□ Barbiturates □ Sulfa □ Codeine
□ Latex □ Other _____

Pharmacy Name: _____ Phone: _____

SIGNATURE

_____ _____
Patient Signature Date

_____ _____
Doctor's Signature Date

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OF BERGEN COUNTY

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. When our office books your appointment, we are setting aside a dedicated chair and time slot just for you, time is reserved, your materials are ordered and we make special arrangements to be ready for your visit. We only ask that if you must reschedule your appointment, that you please provide us with at least 48 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of **$50 per hour** for giving less than 24 hours notice or not showing up to your appointment.

***Repeated cancellations or missed appointments will result in loss of future appointment privileges and appointments will only be made for same day treatment.**

Patient Name: _____ Date: _____

Patient Signature: _____

Doctor's Signature: _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that upon my request, I will receive a copy of the practice's *Notice of Privacy Practices*. I further acknowledge my understanding and agreement to the standards set forth in the notice. I understand the practice will not use my Private Health Information for purposes other than those specifically described in the notice. Additionally, I understand that my Private Health Information may be used at the discretion of the dentist, laboratories, pathologists or other healthcare professionals as necessary to render appropriate diagnosis and/or treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

Doctor's Signature: _____