Patient Registration

Personal Information

Name: _____
First Last Middle Initial

Date of Birth: ____/___/____ Sex: M/F SS#: _____

Address: _____

_____

□ Single □ Married □ Divorced □ Widowed

Phone Numbers: Home:_____
Work: _____
Cell: _____

Emergency Contact & Phone Number: _____

Insurance Information

□ Private (not participating in any dental insurance plans)

□ Dental Insurance

Insured's Name: _____
Insured's Date of Birth: _____
Insured's Social Security Number: _____
Relationship to Patient: _____
Insurance Company: _____
Employer: _____
Group #/Subscriber ID: _____

Assignment and Release (for patients participating in dental insurance only)

I certify that I, and/or my dependent(s), have dental insurance coverage with the insurance company(ies) named above and assign directly to Dr. Daniel J. Kim (Ramsey Dental, P.C.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for notifying Dr. Daniel J. Kim (Ramsey Dental, P.C.) of any changes in insurance coverage. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Daniel J. Kim (Ramsey Dental, P.C.) may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Date Signature of Patient / Legal Guardian (relationship)

Medical Information

Name: Sex: M / F

Date of Birth: / / Occupation:

Physician name & Phone number:

Pharmacy name & Phone number:

Check all that apply (past & present):

☐ Allergy to: __Penicillin or other antibiotics __Codeine or narcotics __Latex
__Other medication(s) _____ __Local Anesthetics __Metals

☐ Cardiac Condition(s):

__Rheumatic Heart Disease
__Artificial Heart Valve(s)
__Shunt / Conduit
__Hypertension
__Angina
__Heart Murmur / Mitral Valve Prolapse
__Congenital Heart Disease / Defect
__Pacemaker
__Previous Bacterial Endocarditis
__Other (specify) _____

☐ Pregnant or nursing
☐ Antibiotic Prophylaxis for dental procedures
☐ Cancer / Chemotherapy / Radiation Treatment
☐ Immunosuppression / Corticosteroid Treatment
☐ Anti-Coagulant Therapy
☐ Osteoporosis
☐ Hepatitis A, B, or C
☐ Tuberculosis
☐ Neurological Disorder
☐ AIDS/HIV
☐ Tobacco use (smoking, snuff, chew)
☐ Respiratory Problems
☐ Artificial Joint Replacement
☐ Diabetes
☐ Hemodialysis
☐ Blood Disease / Disorder
☐ Thyroid problems
☐ Liver Disease
☐ G.E. Reflux
☐ Mental Health Disorder
☐ Sexually Transmitted Disease
☐ Alcohol / Chemical dependency

List all other medical conditions, illnesses, operations, or hospitalizations not indicated above:

List all medication(s) currently taken and corresponding medical conditions: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form.

Date Signature of Patient / Legal Guardian (relationship)

Date Signature of Dentist Comments / Updates

RAMSEY DENTAL, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone:	201-327-4040
Email:	RamseyDental@Gmail.com
Address:	Ramsey Dental, 135 Interstate Shopping Center, Ramsey, NJ 07446

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____

Name (print): _____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Ramsey Dental,P.C.
135 Interstate Shopping Center
Ramsey, NJ 07446

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we require you to sign prior to receiving treatment. All patients must also complete our Patient Registration form, Health History form, and Consent for Use and Disclosure of Health Information form prior to receiving treatment.

PLEASE BE ADVISED THAT IT IS YOUR RESPONSIBILITY TO KNOW YOUR PARTICULAR POLICY AND WHAT IS AND IS NOT COVERED.

Please check with your insurance company prior to making your appointment, as to coverage and benefits information.

CO-PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT.

If we are not a participating provider with your insurance plan, payment is expected in full at the time of your visit. We will provide you with the forms you need to submit to your insurance company.

I HEREBY GIVE AUTHORIZATION AND GUARANTEE PAYMENT FOR ALL SERVICES RENDERED. ALTHOUGH FEES FOR SERVICES ARE DUE AND PAYMENT EXPECTED AT THE TIME SERVICES ARE RENDERED, IF I HAVE BEEN GRANTED A GRACE PERIOD FOR PAYMENT OF FEES, I ACKNOWLEDGE THAT PAYMENT IS DUE AND EXPECTED AT THE TIME THE BILLING STATEMENT IS RECEIVED.

I have read and agree to abide by this policy.

_____

Signature of patient or responsible party *Date*

_____

Name (Print)