SRI Dental, LLC
www.sridental.com
67 Tamarack Circle | Skillman, NJ 08558
smiles@sridental.com
609-921-7744

Welcome to our Practice!

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

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other Birthdate ____/____/_____

Phone: ( ) _____ Preferred Method of Contact: ☐ Call ☐ Text ☐ Email

Other Phone: ( ) _____ Email: _____

Address: _____

City/State/Zip _____ Social Security # _____

How did you hear about us? ☐ Ins Co ☐ Internet ☐ Google ☐ Ad/Mailing Referred by _____

Emergency Contact: _____ Relationship _____ Phone# _____

INSURANCE INFORMATION

Guarantor (Subscriber) Name: _____ (Last) _____ (First) ___ (MI)

Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other _____ Subscriber's DOB: _____/_____/_____

Address (of subscriber, if different than patient): _____

Insurance Company: _____ Insurance Group # _____

Insurance Address: _____ ID#: _____

Payor ID (on insur card) _____

Is there secondary dental insurance? ☐ Yes ☐ No *If yes, please fill out below:*

Subscriber: _____ Insurance Co: _____

Subscriber Birthdate: _____ Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent

Insurance Address: _____

Group #: _____ ID#: _____

ASSIGNMENT AND RELEASE

I, the undersigned hereby assign directly to SRI Dental, LLC all dental benefits, and if any, medical benefits, payable for any services rendered. I further authorize the release of any information necessary to process my insurance claims. In addition, I also authorize the use of this signature on all of my insurance submissions. I agree that a photo or digital copy of this form may be used in lieu of the original. I understand that any payments not made by or denied by the insurance become my responsibility. This authorization will cover all material services rendered, until this authorization is revoked in writing.

Signature of Insured: _____ Date: _____

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MEDICAL HEALTH HISTORY

First Name _____ Last Name _____ Birthdate _____

Physician's Name _____ City/St _____ Phone # _____

Pharmacy Name _____ Phone # _____

Are you under a physician's care? If so, please explain _____
Have you ever been hospitalized or had a major operation? __Y __N Please explain _____
Have you ever had a serious head or neck injury? __Y __N Please explain _____
Do you use or have a history of controlled substances? __Y __N

Please Check Yes or No

Y	N		Y	N		Y	N		Y	N	
		Anemia			Emphysema			Jaundice			Seizures
		Arthritis			Excessive Bleeding			Kidney Disease			Stomach Problems
		Artificial Heart Valve			Fainting			Liver Disease			Stroke _____
		Artificial Joints _____			Glaucoma			Low Blood Pressure			Thyroid Disease
		Asthma			Heart Conditions			Mitral Valve Prolapse			Tuberculosis
		Blood Disease			Heart Lesions			Nervousness/Depression			Ulcers
		Bruise Easily			Heart Murmur			Pacemaker			Venereal Disease
		Cancer _____			Heart Surgery _____			Periodontal Disease			**WOMEN ONLY**
		Chemotherapy			Hepatitis A B C			Radiation Head/Neck			Birth Control
		Diabetes 1 or 2			High Blood Pressure			Respiratory Problems			Nursing
		Dizziness			HIV Positive			Rheumatic Fever			Pregnant

Have you ever had any serious illness not listed above? __Y __N _____

Do you have any of the following drug allergies?

Y	N		Y	N				
		Aspririn			Latex			**Please list other allergies:**
		Codeine			Sulfa			
		Darvon			Percodan			
		Erythromycin			Penicillin			

Please check any of the following drugs you have used at any time

Y	N		Y	N		Y	N		Y	N	
		Fosamax			Didronel			Zometa			Boniva
		Aredia			Actonel			Skelid			Bisphosphonates

List ALL medication you currently take (prescriptions, including vitamins/supplements & over the counter) CHECK HERE ☐ IF LIST ATTACHED

_____ _____ _____ _____
_____ _____ _____ _____

Do you snore loudly or have been told that you snore? __Yes __No
Do you ever awaken with a sensation of gasping for choking? __Yes __No
Has anyone ever noticed that you stop breathing during your sleep? __Yes __No
Do you often wake up with a dry mouth? __Yes __No
Do you find your sleep to be non-freshening? __Yes __No
Do you often feel tired, fatigued, or sleepy during the daytime? __Yes __No
Do you ever fall asleep or nod off in situations where you did not intend to? __Yes __No
Do you have (or ever been treated for) high blood pressure and/or diabetes? __Yes __No

I certify the information recorded on this medical form is correct. I understand it is my responsibility to notify SRI Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications or supplements, I agree to not hold SRI Dental or its employees liable in the event of death of injury.

Signature (Patient/Guardian) _____ Date _____

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DENTAL HEALTH HISTORY

Patient Last Name _____ Patient First Name _____ Birthdate _____

If this is your first time in our office, please answer the following:

Date of your last cleaning _____ *Date of last Oral Cancer Screening?* _____ *Date of last full set of Xrays* _____

What is the most important thing to you about your dental visit today? _____

Do you have any specific concerns/questions about your dental needs? _____

Why did you leave your previous dentist? _____

Please Circle Y or N

Y N Sensitivity to __Hot __Cold __Sweet
Y N Chipped/Broken Teeth
Y N Crooked or Tipped Teeth
Y N Loose Teeth
Y N Missing or Spaces Between Teeth
Y N Catch Food between Teeth
Y N Dry Mouth or Constantly Thirsty
Y N Smoke or Use Chewing Tobacco
Y N Bleeding, Swollen or Irritated Gums
Y N Dissatisfied with Appearance of My Teeth
Y N Frequent Headaches
Y N Jaw Joint Pain
Y N Grinding or Clenching Teeth
Y N Uncomfortable/Uneven When I Bite My Teeth Together
Y N Clicking or Popping of Jaw
Y N Difficulty Opening or Chewing

Please Circle Y or N

Y N Dentures or Partials
Y N Braces / Invisalign
Y N Periodontal Disease/Gum Treatments
Y N Fixed Bridge
Y N Dental Implants
Y N Crowns
Y N Have you had Sedation for Dental Treatment
Y N Veneers
Y N Jaw Surgery
Y N Root Canals
Y N Sleep Apnea
Y N CPAP Machine/Oral Sleep Appliance Date _____
Y N Fear or Anxiety about Dental Treatment

If I could change my smile, I would:

__ Make my teeth whiter
__ Replace missing teeth
__ Repair chipped
__ Replace old crowns/fillings that look dark or don't match
__ Stop my jaw from hurting or clicking
__ Make my teeth straighter
__ Close spaces or gaps that bother me
__ I'm happy with my smile

On a scale of 1-10 *(1 being not very important; 10 being extremely important)*

How important is your dental health to you? _____ *How do you rate your current dental health?* _____

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

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HIPAA OMNIBUS RULE – PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND PRIVACY PRACTICES & CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

Date: _____

Do you have a preference when addressed when summoned from reception area? If so, what _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes, parents, step-parents, grandparents, children or caretakers)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

☐ Any of the following ☐ Cell ☐ Home ☐ Text ☐ Email

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

☐ Any of the following ☐ Cell ☐ Home ☐ Text ☐ Email ☐ None (Opt Out)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS TO BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____
Patient Name Printed Patient/Guardian Signature

_____ _____
Legal Representative/Guardian Relationship of Legal Representative/Guardian

OFFICE USE ONLY:

As a Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

__ It was emergency treatment
__ I could not communicate with the patient
__ The patient refused to sign
__ The patient was unable to sign because _____
__ Other _____

Signature of Privacy Officer: _____

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FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided (we will process insurance claims, provided you have current coverage; see below #4). Our office accepts cash, personal checks, Visa, MasterCard and Discover. Outside financing is available upon request and approval.

[ ] Please check if you would like more information about financing options

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

DO YOU HAVE INSURANCE? Please note:

1. As a courtesy, we will help you process your insurance claims. We will provide an insurance estimate to you (as accurate as possible), however, it is not a guarantee the payment will be exact. Your insurance company and plan benefits ultimately determine the amount paid.
2. All charges incurred are your responsibility regardless of your insurance coverage. Your insurance policy is a contract between you, your employer and your insurance company.
3. Our practice is committed to providing you the best treatment and we charge what is usual and customary in our area.
4. We ask that you pay the deductible and estimated co-payment (which may be estimated) not covered by your insurance – by cash, check or credit card – at the time of service
5. We ask that you sign this form and any other documents that may be required by your insurance company. This form instructs the insurance to pay the office directly.
6. Insurance payments are ordinarily received within 30-60 days of filing. If your insurance company has not made payment within 60 days, we ask that you contact them to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount.
7. We will fully cooperate with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health needs and welcome any questions or concerns you may have.

I HAVE READ, UNDERSTAND AND AGREE. I AUTHORIZE MY INSURANCE COMPANY TO PAY THE DENTAL OFFICE DIRECTLY

Signature _____ Printed Name _____ Date _____

SRI DENTAL

SMILES RENDERED WITH INTEGRITY

CONSENT FORM FOR PHOTOGRAPHY

I consent SRI Dental LLC to use photographs or videos of me (or my minor child) for promotional or educational use. I understand that the photos/videos will only be of me/my minor child's teeth/dental work (no names), unless otherwise indicated and agreed to below.

These images (no names, unless otherwise agreed to below), may appear in advertisement/promotional explanations of dental work/treatment in a variety of marketing advertisements, such as publications, SRI Dental website or social media.

Patient Name _____

Patient Signature _____ Date _____

Minor Name _____

Parent/Guardian Signature _____ Date _____

☐ Permission is granted for in-office identification and diagnostic photos only