Chart #:_____
FOR OFFICE USE ONLY

DATE:_____ **Patient Information**

PATIENT Name: : _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell):_____

Email Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you?_ ☐Another patient, friend ☐ Yellow Pages ☐ Insurance ☐ Work ☐ Other

NAME OF PERSON OR OFFICE REFERRING YOU TO OUR PRACTICE_____

REASON FOR THIS VISIT_____

HEALTH INFORMATION **AGE:**

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____
☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorders/Anemia
☐ Cancer
☐ Cardiac Stents
☐ Chemotherapy
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting / Dizziness
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Headaches/Migraine
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur / MVP
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Nervous Disorder
☐ Osteoporosis
☐ Pacemaker
☐ Pregnancy
☐ Due date:_____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Respiratory Problems
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Surgery
☐ Tuberculosis
☐ Tumors
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
_____
_____
_____

PHARMACY:

Tel: _____

circle one :
SMOKER
NON SMOKER

MEDICATIONS:
_____
_____
_____
_____
_____
_____
_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of PRIMARY CARE PHYSICIAN: _____ Phone_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:**_____
Signature of patient, parent or guardian

DENTAL / SOCIAL HISTORY **FOR OFFICE USE ONLY**

PREVIOUS DENTIST:_____Date of Last Visit_____
Children/Other family members:_____
- Any complications following dental treatment? ☐ Yes ☐ No _____
- Any History of Anxiety Associated with Dental Tx:_____
- REGULAR DENTAL VISITS ☐ Yes ☐ No DAILY ORAL HYGIENE_____
- HISTORY: ORTHO_____ PERIO _____ TMJ_____
  SURGERY_____ADVANCED DENTAL CARE_____
  PREMEDICATION:_____ORAL LESIONS_____
- SMILE RATING_____Misc:_____

Spouse or Responsible Party Information

_____**CHECK HERE IF SAME AS PATIENT**

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary Insurance Carrier_____

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 Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance Carrier_____

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 Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible part

Cathy M. Andricsak, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone: E-mail:
Social Security #:

SECTION B: TO THE PATIENT/GUARDIAN — 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
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:
Cathy M. Andricsak, D.M.D. 418 Hooper Ave Toms River, , NJ 08753 (732)244-3444

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: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.
HIPAA web site: http://www.hhs.gov/ocr/hipaa/finalreg.html

You May Refuse to Sign This Acknowledgement*
I, _____, have received acknowledgement of this office's Notice of Privacy Practices.

_____ Date:
Signature

For Office Use:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)
_____
_____