Dental Registration and History

PATIENT INFORMATION

Patient Name: ______________________________ SS/v/Patient ID #: ____________
Last Name *First Name* *M.I.*

Sex: M ☐ F ☐ Birth Date: ____________ Email: ____________________ Phone: ____________
MM/DD/YYYY

Address: ____________________ City: ____________ State: ______ Zip: ______

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered ☐

Employer: ____________________ Occupation: ____________ Employer Phone: ____________

Employer Address: ____________________ City: ____________ State: ______ Zip: ______

DENTAL INSURANCE

Account Owner: ____________________ Relationship: ____________

Insurance Company: ______________________________

Group #: ____________________ *Is the patient covered by additional insurance?* Yes ☐ No ☐

Subscriber's Name: ____________________ Birth Date: ____________ SS #: ____________
MM/DD/YYYY

Insurance Company: ______________________________

Group #: ____________________ Relationship: ____________

AGREEMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to Dr. ____________________ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ____________
Signature of Patient, Parent, Guardian or Personal Representative *Date*

______________________________ ____________
Please print name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*

EMERGENCY CONTACT

Name: ______________________________ Relationship: ____________
Last Name *First Name* *M.I.*

Email: ____________________ Phone: ____________

Name: ______________________________ Relationship: ____________
Last Name *First Name* *M.I.*

Email: ____________________ Phone: ____________

DENTAL HISTORY

Reason for today's visit: ____________________ Former dentist: ____________

____________________ City/State: ____________

Date of last dental visit: ____________________ Date of last dental X-rays: ____________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition		Condition		Condition	
Bad breath	Yes ☐ No ☐	Food collection between the teeth	Yes ☐ No ☐	Orthodontic treatment	Yes ☐ No ☐
Bleeding gums	Yes ☐ No ☐	Foreign objects	Yes ☐ No ☐	Pain around ear	Yes ☐ No ☐
Blisters on lips or mouth	Yes ☐ No ☐	Grinding teeth	Yes ☐ No ☐	Periodontal treatment	Yes ☐ No ☐
Burning sensation on tongue	Yes ☐ No ☐	Gums swollen or tender	Yes ☐ No ☐	Sensitivity to cold	Yes ☐ No ☐
Chew on one side of mouth	Yes ☐ No ☐	Jaw pain or tiredness	Yes ☐ No ☐	Sensitivity to heat	Yes ☐ No ☐
Cigarette, pipe, or cigar smoking	Yes ☐ No ☐	Lip or cheek biting	Yes ☐ No ☐	Sensitivity to sweets	Yes ☐ No ☐
Clicking or popping of jaw	Yes ☐ No ☐	Loose teeth or broken fillings	Yes ☐ No ☐	Sensitivity when biting	Yes ☐ No ☐
Dry mouth	Yes ☐ No ☐	Mouth breathing	Yes ☐ No ☐	Sore or growths in your mouth	Yes ☐ No ☐
Fingernail biting	Yes ☐ No ☐	Mouth pain, brushing	Yes ☐ No ☐		

How often do you floss? ____________ How often do you brush? ____________

HEALTH HISTORY

Physician's Name: ____________ Date of last visit: ____________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes ☐ No ☐

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes ☐ No ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition		Condition		Condition	
AIDS / HIV	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Fainting or dizziness	Yes ☐ No ☐	Respiratory Disease	Yes ☐ No ☐
Arthritis / Rheumatism	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Scarlet Fever	Yes ☐ No ☐
Artificial Joints	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Shortness of Breath	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Heart Problems	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Back Problems	Yes ☐ No ☐	Hepatitis Type ______	Yes ☐ No ☐	Skin Rash	Yes ☐ No ☐
Bleeding abnormally with surgery	Yes ☐ No ☐	Herpes	Yes ☐ No ☐	Special Diet	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐	Swollen Feet or Ankles	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Jaw Pain	Yes ☐ No ☐	Swollen Neck Glands	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Circulatory Problems	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Congenital Heart Lesions	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Cortisone Treatments	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐	Tumor or growth on head or neck	Yes ☐ No ☐
Cough, persistent or bloody	Yes ☐ No ☐	Nervous Problems	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐	Weight Loss, unexplained	Yes ☐ No ☐

Women:
Are you pregnant? Yes ☐ No ☐ Due Date: ______ Are you nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name: ____________

Phone: ____________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______

UPDATE

Has there been any changes in your health since your last dental appointment? Yes ☐ No ☐

For what conditions? ____________

Are you taking any medications? ______ If so, what? ____________

Patient's Signature: ____________ Date: ______

Doctor's Signature: ____________ Date: ______

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Has there been any changes in your health since your last dental appointment? Yes ☐ No ☐

For what conditions? ____________

Are you taking any medications? ______ If so, what? ____________

Patient's Signature: ____________ Date: ______

Doctor's Signature: ____________ Date: ______

Louis B. Conte, DMD
General Dentistry

Louis B. Conte, DMD
223 Maple Ave. Red Bank, NJ 07701
(732) 758-0414
drlconte@gmail.com

CANCELLATION - NO SHOW POLICY

Louis B. Conte General Dentistry charges a fee for missed appointments. It is not our intent to inconvenience any of our patients but in order to run our office as efficiently as possible, we need to utilize canceled appointments for other patients.

Please read our CANCELLATION POLICY carefully.

Louis B. Conte General Dentistry asks that all patients give the office a:

- MINIMUM of a 24 hour notice if a scheduled appointment cannot be kept. A fee of $50.00 will be charged if the office is not notified of the cancellation.
- MINIMUM of 48 hours notice if a scheduled surgery (i.e. implant, extractions, etc.) cannot be kept. A fee of 10% of your treatment cost will be charged if the office is not notified of the cancellation.
- An appointment is considered missed if 24/48 hours notice is not given to the office.
- PLEASE DO NOT CALL THE AFTER HOURS SERVICE. Patients must speak directly to the office.

Thank you for your cooperation.

Patient Name: ______________________________ Date: __________

Patient's Signature: ______________________________

Louis B. Conte, DMD
General Dentistry

Louis B. Conte, DMD
223 Maple Ave. Red Bank, NJ 07701
(732) 758-0414
drlconte@gmail.com

PRIVACY PRACTICES ACKNOWLEDGMENT

Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: ______________________________ Birthdate: __________

Patient's Signature: ______________________________

Date: ______________________________

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the med-

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ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.