Registration and History

Patient Information

Today's Date: _____

Patient's Name: _____ Patient's Birthdate: _____

Patient's Social Security Number: _____ Patient's Sex: ☐ Male ☐ Female

Patient's Address: _____ Town / City: _____

State: _____ Zip: _____

Patient's Contact Information: Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____ Other: _____

Patient's Employer: _____

Employer's Address: _____

Patient's Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

**** Whom may we thank for referring you? _____

Account Responsibility

Who is responsible for this account? _____ SS# _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Phone #'s: H: _____ W: _____ Relationship to patient _____

Employer _____ Employer Address _____

Insurance Company _____ Plan name / type _____

Ins. co. phone # _____ Group # _____ Is additional dental ins. involved? ☐ Yes ☐ No

Dental History ****** DO NOT DRAW LINES THRU BOXES: CHECK INDIVIDUALLY!!!***

Reason for today's visit _____ Former Dentist _____

Date of last visit _____ City/State _____

Please mark each box below individually to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Bleeding gums	☐	☐	Blisters on lip or mouth	☐	☐
Click or pop in jaw	☐	☐	Dry mouth	☐	☐	Fingernail biting	☐	☐
Habitual placement of objects in teeth/mouth	☐	☐	Burning sensation on tongue	☐	☐	Chew on one side of mouth	☐	☐
Smoke	☐	☐	Grind teeth	☐	☐	Swollen / tender gums	☐	☐
Jaw pain, tiredness	☐	☐	Lip or cheek biting	☐	☐	Loose teeth	☐	☐
Broken fillings	☐	☐	Mouth breathing	☐	☐	Pain when brushing	☐	☐
Orthodontic treatment	☐	☐	Periodontal treatment	☐	☐	Hot / cold sensitivity	☐	☐
Sensitivity to sweets	☐	☐	Sensitivity when biting	☐	☐	Sores / growths in mouth	☐	☐

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

Medical History *** *DO NOT DRAW LINES THRU BOXES: CHECK INDIVIDUALLY!!!*

Physician's name _____ Town, State _____ Last Visit _____

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

	Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Epilepsy	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Scarlet Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Shortness of Breath	☐	☐
Artifical Heart Valves	☐	☐	Headaches	☐	☐	Sinus Trouble	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Skin Rash	☐	☐
Asthma	☐	☐	Heart Problems	☐	☐	Special Diet	☐	☐
Back Problems	☐	☐	Hepatitis: Type _____	☐	☐	Stroke	☐	☐
Bleeding abnormally with extractions	☐	☐	Herpes	☐	☐	Swelling of ankles or feet	☐	☐
			High blood pressure	☐	☐			
Blood disease	☐	☐	HIV Positive	☐	☐	Swollen neck glands	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Kidney Disease	☐	☐	Tumor or growth on head or neck	☐	☐
Circulatory problems	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesion	☐	☐	Low Blood Pressure	☐	☐	Ulcer	☐	☐
			Mitral Valve Prolapse	☐	☐	Unexplained weight loss	☐	☐
Cortisone Treatments	☐	☐	Nervous Problems	☐	☐			
Cough, persistent or bloody	☐	☐	Pacemaker	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐	Women:		
Emphysema	☐	☐	Radiation Treatment	☐	☐	Are you pregnant	☐	☐
Do you wear contact lenses	☐	☐	Respiratory Disease	☐	☐	Are you nursing	☐	☐

Medications

- Do you take any bisphosphonates? Yes ☐ No ☐
- List all medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

☐ Aspirin ☐ Local anesthetic
☐ Barbituates ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Iodine ☐ Latex
☐ Other:

_____ _____

_____ _____

Certification

I hereby certify that all of the information provided on this form is as complete and accurate as possible.

_____ _____
Signature Date

Doctor Review

_____ _____
Signature Date

In Case of An Emergency:

Who should we contact?

Name _____

Relationship _____
Home phone # _____
Work phone # _____
Additional Phone # _____

Hamburg Family & Cosmetic Dental Group, LLC

Jinu Kurian, DDS

Office Procedures & Policies
Consent for Treatment
Authorization for Insurance Submission

Here at Hamburg Family & Cosmetic Dental Group, LLC, we are proud to offer high quality dental care with individualized attention. To best serve our patients, we have designed the following procedures and policies. Each section also requires your initials. Please feel free to ask us any questions. Thank you.

Insurance, Payment, and Financing

I. Insurance

If you have insurance, we are anxious to help you receive maximum benefits. Insurance is not a simple matter these days. As a courtesy to you, we will explore and explain your benefits, and we will also submit your insurance claims for you. **Please note that unpaid balances from your insurance company become your responsibility.** *Initials* _____

II. Payment

Unless **previous** arrangements have been made, payment is expected at time of service. When multiple visits are required for treatment, your payment may be split over the number of visits required. If you have insurance, we will estimate the portion you are responsible for. However, if your company does not pay in full, you are responsible for the difference. We accept cash, checks Visa, MasterCard, Discover, or AMEX.

If final payment cannot be made when services are completed, the balance MUST be placed on a credit card. If you do not have a credit card, a separate Financial Agreement Form will be filled out and signed by you. A copy of your driver's license, plus other documentation, will also be required.

If extensive treatment is necessary, you will most likely have a consultation appointment, which will include financing options. Please see the next section for details. *Initials* _____

III. Financing

We offer multiple financing options for extensive treatment. These options include "Pay As You Go," "Payment By Phase," "Healthcare Financing Options," and "Automatic Credit Card Payment" options. Our "Financing Options" form lists details. Please ask us for one if you are curious and will be inquiring about financing. *Initials* _____

Miscellaneous

A. Bounced checks are subject to a $30 fee.

B. Outstanding Balances:

Anyone leaving the office with an outstanding balance, especially when previously agreed-upon arrangements have been broken, will be required to sign a Financial Agreement.

C. Interest Charges and Failure to Pay Accounts:

Any outstanding balances not paid within 30 days of receiving a statement will be subject to interest at 18% APR or a $3.00 service charge, whichever is greater. Failure to make full payment within 90 days will result in the actions of a collection agency or court, with an additional collection fee of $150.00, plus reasonable attorney fees.

D. Cancellation Policy

For most appointments, we require 24 hour notice if you are unable to keep your appointment. **Some appointments require 48 or 72 hour notice, and you will be informed of these**, **as necessary**. Failure to give us this notice will result in a $15 charge per quarter hour scheduled. We are well aware

that emergencies arise, and we are not insensitive to this issue. However, if you do not call us to let us know what is occurring, we reserve the right to impose this fee. We cannot provide our patients with the level of excellence expected of us if we do not have your cooperation with respect to keeping your appointments.

E. Confirmation Policy

We will call you the day before to remind you of your appointment. If your appointment is more than one week away, you will receive two calls: one a week before, and a second call the day before. Saturday appointments will be confirmed on Thursdays. **Please note that these calls are courtesy calls: your appointment is still your responsibility.**

Initials _____

I have read all the above sections, and all my questions have been answered to my satisfaction.

Name (print) _____

Signature _____ Date _____

I hereby give consent for the following minors: (FIRST AND LAST NAMES!!):

Name of Minor (First & Last Name)	My relationship to minor	Name of Minor (First & Last Name)	My relationship to minor
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL CONSENT FOR TREATMENT

I understand that all dental and anesthetic procedures have associated risks. These may be but are not limited to:

1) Drug reactions & side effects 2) Damage to adjacent teeth or fillings

3) Post-operative infection 4) Post-operative bleeding that might require additional treatment

5) Bruising, swelling, sensitivity, or pain

6) Failure of the dental procedure necessitating additional treatment

7) Complications during treatment necessitating referral to a specialist.

I understand I have the right to ask questions about my treatment, including alternatives and risks, as well as the consequences of doing nothing. I further understand that no guarantees have been made or offered.

Patient (or guardian) Signature _____ Date _____

PAYMENT ASSIGNMENT AND RELEASE

I understand that I am fully responsible for this account, and for all minors listed above. In the event that insurance is involved, I authorize all insurance benefits be payable to this dental practice. 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 from the insurance company. I authorize the use of this signature on all insurance submissions.

_____	_____	_____	_____
Print Name of Responsible Person	Sign Name of Responsible Person	Relationship to Patient	Date

Hamburg Family & Cosmetic Dental Group, LLC

Jinu Kurian, DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (Jan. 1, 2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $30 per set of x-rays, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also 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 with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jinu Kurian, DDS 973-209-6252 drkurian@hamburgdental.com
15 Vernon Ave., Suite 101, Hamburg, NJ 07419

Hamburg Family & Cosmetic Dental Group, LLC

Jinu Kurian, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: 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. If you wish to have a copy to take with you, please let us know. 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 post a revised Notice of Privacy Practices in our administrative area, 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 viewing our website, or contacting our office:

Hamburg Family & Cosmetic Dental Group, LLC 15 Vernon Ave, Ste 101, Hamburg, NJ 07419

Phone: 973-209-6252 Fax: 973-209-8787 E-mail: drkurian@hamburgdental.com

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 heath care operations.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT: PLEASE ASK FOR YOUR COPY.

Hamburg Family & Cosmetic Dental Group, LLC

Jinu Kurian, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION – minor or unable to sign for self

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SECTION A: PATIENT

Name: _____

SECTION B: 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. If you wish to have a copy to take with you, please let us know. 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 post a revised Notice of Privacy Practices in our administrative area, 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 viewing our website, or contacting our office:

Tri-State Center for Implant & Cosmetic Dentistry, PC, 15 Vernon Ave, Ste 101, Hamburg, NJ 07419

Phone: 973-209-6252 Fax: 973-209-8787 E-mail: drkurian@hamburgdental.com

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
(print name of Patient's representative)

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 Patient's protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT: PLEASE ASK FOR YOUR COPY.

Hamburg Family & Cosmetic Dental Group, LLC

Jinu V. Kurian, DDS

15 Vernon Avenue, Suite 101
Hamburg, NJ 07419

Tel: (973) 209-6252 Fax: (973) 209-8787
www.hamburgdental.com

I, _____, direct my dental services provider and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Health Information to be disclosed upon the request of the person named above --
(Circle either A or B):

A. **Disclose** my complete dental record (including but not limited to diagnoses, prognosis, treatment, and billing, for all conditions) **OR** scheduling also

B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
Mental health records
Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment
Other (please specify):

_____
_____

This authorization shall be effective immediately unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date