PATIENT INFORMATION

NAME_____HOME PHONE_____

WORK PHONE_____ CELL PHONE_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

EMAIL_____DENTAL INSURANCE: YES____ NO _____

SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH_____

NEAREST RELITIVE NOT LIVING WITH YOU_____

THEIR PHONE NUMBER_____

WHOM TO WE CONTACT IN CASE OF EMERGENCY_____

THEIR PHONE NUMBER _____

PREVIOUS DENTIST _____

OFFICE PHONE NUMBER_____

WHO MAY WE THANK FOR REFERING YOU ? _____

DATE _____ DATE OF BIRTH _____

NAME _____ ADDRESS _____ H: PHONE B: _____

PHYSICIAN _____ ADDRESS _____ PHONE _____

GENERAL HEALTH HISTORY

Have you had any of the following:

Diabetes: _____ Lung condition: _____ Heart condition: _____ Rheumatic fever: _____

Abnormal Blood Pressure: _____ Arthritis: _____ Liver condition: _____ Ulcer: _____

Anemia: _____ Radiation treatment: _____ Headaches: _____ Neuralgia: _____

Sinus trouble: _____ Frequent colds: _____ Sore throat: _____

Hepatitis: _____ V.D. _____ HIV Pos: _____ AIDS: _____

Additional: _____

Are you under the care of a physician now: _____

Are you receiving medication now: _____ What: _____

Are you taking or have you ever taken: ZOMETA ___ BONIVA ___ ACTONEL ___ FOSA MAX ___ AREDIA ___ RECLAST ___ or any other Bone strengthening drugs (BISPHOSPHONATES) _____

Are you allergic to any of the following:

Penicillin: _____ Sulfa: _____ Codeine: _____ Aspirin: _____ Dental injections: _____ Additional: _____

Are you pregnant: _____ What month: _____

Do you heal slowly if cut or bruised: _____ Do you get black & blue easily: _____

Have you ever had surgery: _____ What for: _____

What type of work do you do: _____

DENTAL QUESTIONNAIRE

Are you teeth sensitive to sweets: _____ Hot: _____ Cold: _____ Chewing: _____

Have you ever had fluoride treatments: _____ Fluoride pills: _____

Have you had any toothaches or swellings recently: _____ When: _____

Have you ever had your teeth straightened: _____

Do you gums bleed easily: _____ Have you had mouth infections: _____ Sores: _____

Are you conscious of a bad taste at times: _____ Mouth odor: _____

Do you grind or clench your teeth: _____ Does food wedge between your teeth: _____

Have you ever had periodontal (gum) treatments: _____

Are you happy with your smile: _____

Do you feel self-conscious about the way your teeth look to others: _____

Does fear keep you from going to the dentist: _____

Do you like an anesthetic when having work done on you teeth: _____

Are there any procedures that you dislike about dental treatments: _____

What do you want in dentistry: _____

Emergency treatment only: _____ Corrections: _____ Prevention: _____

Please feel free to ask any questions.

HERBERT J. SCHNEIDER D.M.D., F.A.G.D., F.A.E.S.
55 GRANT AVENUE DUMONT, N.J. 07628
TELEPHONE (201) 385-5538 FAX (201) 385-9808

FINANCIAL AND DENTAL INSURANCE OFFICE POLICIES

WE ARE COMMITED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE DENTAL INSURANCE, WE WILL DO OUR BEST TO HELP YOU MAXIMIZE YOUR ALLOWABLE BENEFITS. IF NO INSURANCE IS INVOLVED, WE WILL HELP YOU SET UP A PAYMENT PLAN THAT WILL FIT YOUR BUDGET.

WE ASK THAT YOU PAY YOUR CO-PAYMENT AND/OR PERCENTILE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS AND MAJOR CREDIT CARDS. WE WILL GLADLY DISCUSS YOUR PROPOSED TREATMENT AND ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE. WE WILL BE HAPPY TO PROCESS YOUR INSURANCE CLAIM FORM FOR YOU, AND RESUBMIT ANY CLAIMS THAT ARE OVER 30 DAY'S UNANSWERED BY YOUR INSURANCE COMPANY. WE ALSO WILL COMPLY WITH ANY REASONABLE REQUEST FOR ADDITIONAL INFORMATION REGARDING THE CLAIM.

RETURNED CHECKS AND OVERDUE ACCOUNTS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES OF 1 1/2 % PER MONTH, 18 % APR. CHARGES MAY ALSO BE MADE FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 24 HOUR ADVANCED NOTICE.

I UNDERSTAND AND AGREE (THAT REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT. I HAVE READ THE INFORMATION AND FILLED OUT THE PATIENT INFORMATION AND HEALTH FORMS, AND CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL ALSO UPDATE MY HEALTH STATUS SHOULD IT CHANGE.

SIGNATURE_____ DATE_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Dr Herbert J Schneider and Dr Rachel G Jacobs

Name: _____ **Date of Birth:**_____

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.

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.

SIGNATURES

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: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature:_____ 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: _____

Herbert J. Schneider, D.M.D.
Rachel G. Jacobs, D.M.D.
55 Grant Ave. * Dumont, N.J. 07628
Phone: 201 385-5538
Fax : 201 385-9808

Patient Insurance Information

Policy Holder's Name_____

Policy Holder's Address _____

_____

Policy Holder's Phone # (Circle One – Work / Home / Cell)_____

Policy Holder's Date Of Birth_____

Policy Holder's Social Security #_____-_____-_____

Employer's Name _____

Employer's Phone # _____

Name of Dental Insurance ***_____

Policy / Group # _____

Name of Dependant and Relationship to Policy Holder

Spouse / Partner _____

Son / Daughter _____ Son / Daughter _____

Son / Daughter _____ Son / Daughter _____

Son / Daughter _____ Son / Daughter _____

***Please bring your Dental Card with you so we may make a copy