SOUTH JERSEY
PERIODONTICS

SAMIR SHAH, DMD, MS

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ___/___/_____ ☐ Male ☐ Female

Social Security Number: ___-___-_____ Occupation: _____

Email: _____ Referred By: _____

Emergency Contact: _____ Emergency Contact Phone: _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance** (leave blank if n/a)
Name of Dental Insurance: _____	Name of Dental Insurance: _____
Subscriber name: _____	Subscriber name: _____
Subscriber ID: _____	Subscriber ID: _____
SSN: ___-___-_____	SSN: ___-___-_____
Date of Birth: ___/___/_____	Date of Birth: ___/___/_____
Employer Name: _____	Employer Name: _____
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

We only accept Dental insurance, Medical Insurance will not cover dental procedures.

ELECTRONIC COMMUNICATIONS

I consent to receiving HIPAA compliant electronic communications, such as email or text messages regarding appointment times, treatment, and payment. I understand that there is no obligation to receive these electronic communications and I may opt-out by clicking the unsubscribe link provided in emails or by contacting our office.

AUTHORIZATION /NOTICE OF PRIVACY PRACTICES

I consent to the diagnostic and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluation and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist and understand that my insurance benefits may pay less than the actual bill for service and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I acknowledge that I have had the opportunity to read South Jersey Periodontics **HIPAA Notice of Privacy Practices.**

Patient Signature: _____ **Date:** _____

PATIENT NAME: _____ **DATE:** _____

SOUTH JERSEY PERIODONTICS IS COMMITTED TO PROVIDING YOU WITH THE HIGHEST QUALITY CARE AND WE ARE PLEASED TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, OR YOUR RESPONSIBILITY.

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND CARE CREDIT.**
- **SOUTH JERSEY PERIODONTICS PROVIDES COMPLIMENTARY INSURANCE COMPANY BILLING. THE PATIENT PORTION OF A PARTICULAR DENTAL SERVICE IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

INSURANCE

SOUTH JERSEY PERIODONTICS PROVIDES INSURANCE COMPANY BILLING TO ASSIST YOU WITH PROCESSING OF YOUR INSURANCE CLAIMS. WE WILL BILL YOUR INSURANCE FOR ANY EXAMINATIONS OR PROCEDURES THAT HAVE BEEN PERFORMED IN OUR OFFICE. IF THE INSURANCE DENIES OUR CLAIM, THE PATIENT/GUARDIAN WILL BE RESPONSIBLE FOR THE FEE OF THE PARTICULAR SERVICE.

INSURANCE LIMITATIONS

MOST INSURANCE COMPANIES HAVE AN ANNUAL LIMITATION FOR THE AMOUNT OF DENTAL SERVICES THAT CAN BE REIMBURSED WITHIN EACH PLAN YEAR. IF YOU OR YOUR FAMILY MEMBER EXCEED THESE ANNUAL LIMITATIONS IN ANY PLAN YEAR, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF DENTAL SERVICES THAT EXCEED THE PARTICULAR PLAN'S LIMITATIONS. THE PATIENT IS RESPONSIBLE FOR MONITORING THE AMOUNT OF HIS/HER REMAINING BENEFITS FOR ANY ANNUAL BENEFIT PERIOD.

PRE-DETERMINATIONS

ADDITIONALLY, WE WILL SUBMIT YOUR TREATMENT PLAN FOR A PRE-DETERMINATION OF YOUR INSURANCE BENEFITS. SUBMITTING A PRE-DETERMINATION ALLOWS US TO RECEIVE AN ESTIMATE OF WHAT YOUR INSURANCE COMPANY ALLOWS IN TERMS OF TREATMENT AND COVERAGE. *THIS AMOUNT IS ONLY AN ESTIMATE AND NOT A GUARANTEE OF PAYMENT BY THE INSURANCE COMPANY.*

PATIENT PORTION

WE WILL DO OUR BEST TO INFORM YOU OF YOUR ESTIMATED PATIENT PORTION PRIOR TO YOUR APPOINTMENT. THIS ESTIMATED PATIENT PORTION IS DUE AT THE TIME OF SERVICE. YOU AS A PATIENT ARE ALWAYS RESPONSIBLE FOR ANY FEES THAT ARE NOT COVERED BY YOUR INSURANCE COMPANY.

INITIAL HERE X_____

IF YOU FEEL AS THOUGH YOUR INSURANCE COMPANY HAS PROVIDED INACCURATE INFORMATION REGARDING YOUR DENTAL BENEFITS, WE RECOMMEND THAT YOU CONTACT YOUR INSURANCE COMPANY TO RESOLVE THE ISSUES. KNOWING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY AND YOU MUST CONTACT YOUR INSURANCE REGARDING QUESTIONS YOU MAY HAVE ABOUT YOUR COVERAGE. AS A DENTAL OFFICE WE CAN ONLY SUBMIT CLAIMS ON YOUR BEHALF. WE DO NOT SUBMIT TO MEDICAL INSURANCE COMPANIES AND WE DO APOLOGIZE FOR ANY INCONVENIENCE THIS MAY CAUSE.

CANCELLATION POLICY

WHEN OUR OFFICE BOOKS YOUR APPOINTMENTS, WE ARE SETTING ASIDE A DEDICATED CHAIR AND TIME SLOT JUST FOR YOU. WE WILL CONFIRM YOUR APPOINTMENT BY TEXT MESSAGE, EMAIL, AND/OR PHONE AT MULTIPLE TIME INTERVALS BEFORE YOUR APPOINTMENT. IF WE HAVE NOT RECEIVED CONFIRMATION WITHIN 24 HOURS OF YOUR APPOINTMENT, WE WILL ASSUME YOU ARE NOT COMING AND WE WILL OPEN UP THE TIME SLOT FOR ANOTHER PATIENT. IF YOU SHOW UP TO AN APPOINTMENT WE WERE UNABLE TO CONFIRM AND THE TIME SLOT HAS BEEN ALLOTTED TO ANOTHER PATIENT, WE WILL RESCHEDULE YOU. FURHERMORE, IF YOU ARE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT TIME, WE WILL NOT HAVE ENOUGH TIME REMAINING TO PROVIDE YOU WITH QUALITY CARE AND YOUR APPOINTMENT WILL BE RESCHEDULED.

WE ASK THAT IF YOU MUST RESCHEDULE OR CANCEL YOUR APPOINTMENT, YOU PROVIDE US WITH **AT LEAST 24 HOURS NOTICE**. THIS COURTESY MAKES IT POSSIBLE TO GIVE YOUR RESERVED TIME SLOT TO ANOTHER PATIENT WAITING TO BE SEEN. RESCHEDULING OR CANCELLING AN APPOINTMENT LESS THAN 24 HOURS IN ADVANCE WILL RESULT IN A CANCELLATION FEE AT THE FOLLOWING RATES:

- **$50 FEE FOR AN APPOINTMENT WITH A HYGIENIST**
- **$100 FEE FOR AN APPOINTMENT WITH DR. SHAH**

INITIAL HERE X_____

SHOULD A PATIENT MISS, NO SHOW, OR LATE CANCEL MULTIPLE APPOINTMENTS AND WISH TO SCHEDULE ANOTHER, A **NON-REFUNDABLE DEPOSIT** WILL BE REQUIRED TO RESERVE THE APPOINTMENT TIME.

DELIQUENT PAYMENTS

IT IS OUR POLICY THAT IF YOUR ACCOUNT IS MORE THAN 60 DAYS OVERDUE (AND NOT PENDING INSURANCE PAYMENT), WE WILL NOT BE ABLE TO SCHEDULE YOUR NEXT APPOINTMENT UNTIL YOUR BALANCE IS SATISFIED. WE WILL SEND YOU A BILL EVERY 30 DAYS. AFTER 90 DAYS, IF WE HAVE NOT RECEIVED PAYMENT, YOU WILL RECEIVE A NOTICE PRIOR TO SUBMISSION TO A COLLECTION AGENCY. YOU WILL HAVE ANOTHER 10 DAYS TO PAY YOUR BALANCE OR THE ACCOUNT WILL BE SENT TO COLLECTIONS. ALL FEES INCURRED DURING THIS PROCESS WILL BE APPLIED TO YOUR BALANCE.

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE WITH THESE TERMS.

SIGNATURE OF RESPONSIBLE PARTY: _____ **DATE:** _____

MEDICAL HISTORY

NAME: _____ **DATE:** _____

AS REQUIRED BY LAW, OUR OFFICE ADHERES TO WRITTEN POLICIES AND PROCEDURES TO PROTECT THE PRIVACY OF INFORMATION ABOUT YOU THAT WE CREATE, RECEIVE, OR MAINTAIN. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE KEPT CONFIDENTIAL SUBJECT TO APPLICABLE LAWS. HEALTH PROBLEM THAT YOU MAY HAVE, OR MEDICATION THAT YOUR MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE CARE YOU RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

DO YOU USE CONTROLLED SUBSTANCES? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

DO YOU SMOKE OR USE SMOKELESS TOBACCO? ☐ YES ☐ NO

--------IF YES, HOW MUCH PER DAY AND FOR HOW MANY YEARS? _____/ DAY _____ YEARS

DO YOU HAVE AN ARTIFICIAL JOINT? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

WOMEN: ARE YOU PREGNANT OR NURSING? ☐ YES ☐ NO

PLEASE LIST THE NAMES OF ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

DO YOU TAKE ANY NON-ASPIRIN MEDICATIONS AS A BLOOD THINNER (IE. **COUMADIN, WARFARIN, PLAVIX**, ETC.)? ☐ YES ☐ NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ ASPIRIN ☐ CODEINE ☐ LATEX
☐ SULFA DRUGS ☐ LOCAL ANESTHETICS ☐ PENICILLIN ☐ OTHER: _____

CURRENT HEALTH:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

HEART MURMUR	☐ YES ☐ NO	PACEMAKER	☐ YES ☐ NO	CHEMOTHERAPY	☐ YES ☐ NO
MITRAL VALVE PROLAPSE	☐ YES ☐ NO	ANEMIA	☐ YES ☐ NO	RADIATION	☐ YES ☐ NO
ARTIFICIAL HEART VALVE	☐ YES ☐ NO	AIDS OR HIV	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO
CARDIOVASCULAR DISEASE	☐ YES ☐ NO	AUTOIMMUNE DISEASE	☐ YES ☐ NO	THYROID PROBLEMS	☐ YES ☐ NO
ANGINA	☐ YES ☐ NO	RHEUMATOID ARTHRITIS	☐ YES ☐ NO	STROKE	☐ YES ☐ NO
CONGESTIVE HEART FAILURE	☐ YES ☐ NO	LUPUS	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO
DAMAGED HEART VALVE	☐ YES ☐ NO	ASTHMA	☐ YES ☐ NO	HEPATITIS B OR C	☐ YES ☐ NO
HEART ATTACK	☐ YES ☐ NO	EMPHYSEMA	☐ YES ☐ NO	EPILEPSY/SEIZURES	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO	KIDNEY PROBLEM	☐ YES ☐ NO
CONGENITAL HEART DEFECTS	☐ YES ☐ NO	CANCER	☐ YES ☐ NO	OSTEOPOROSIS	☐ YES ☐ NO

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? ☐ YES ☐ NO IF YES, EXPLAIN:_____

HAS A PHYSICIAN RECOMMENDED THAT YOU TAKE ANTIBIOTICS PRIOR TO DENTAL APPOINTMENTS? ☐ YES ☐ NO

DENTAL HISTORY:

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING?

☐ BLEEDING GUMS ☐ RECEDING GUMS ☐ MISSING TEETH
☐ SENSITIVITY TO HOT/COLD/SWEETS ☐ FOOD COLLECTION BETWEEN TEETH ☐ DRY MOUTH
☐ OTHER TOOTH PAIN: _____

DATE OF LAST DENTAL EXAM, X-RAYS, AND CLEANING. EXAM: _____/_____/_____ X-RAYS: _____/_____/_____ CLEANING: _____/_____/_____

HAVE YOU EVER HAD:

PREVIOUS PERIODONTAL (GUM) TREATMENT? ☐ YES ☐ NO
ISSUES WITH PREVIOUS DENTAL TREATMENT? ☐ YES ☐ NO
ISSUES WITH LOCAL ANESTHETICS (NOVACAINE)? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: / /