*Krause Comprehensive Dental Care*
*150 River Road, J-2*
*Montville, NJ 07045*

*Tel: (973) 334-5556*
*Fax: (973) 331-0134*
*Email: medhx@kcdcmontville.com*

# *Medical History*

**Today's Date: _____**

**Patient Name: (Last) _____(First) _____**

**Address_____ City_____ State_____ Zip_____**

**Telephone: (Home) _____ (Work) _____ (Cell)_____**

**Email: _____ Date of Birth:_____/_____/_____Social Security #:_____-_____-_____**

## *Employment:*

**Occupation:_____Employer:_____**

**Bus. Address_____City_____State_____Zip_____**

## *Patient Information:*

**Marital Status:** Single

If married, spouse's name_____ Cell Tel. No._____

**In case of emergency,**

Name of nearest relative not living with you_____Tel: (_____) _____

Name of nearest friend not living with you_____Tel: (_____)_____

**Name of your physician:_____ Tel:** (_____)_____

Name of previous dentist:_____Tel (_____)_____

**Whom may we thank for referring you to our office?_____**

## *Financial:*

Insurance Coverage? ☐ Yes ☐ No If yes, please indicate Subscriber's Name, Date of Birth, Ins. ID#, Insurance Carrier Name & Policy No. _____

_____

**Name of person financially responsible for my dental treatment_____**

***Medical:***

(In the following questions, indicate YES or NO, whichever applies. Your answers are for our records only, and will be kept strictly confidential.)

My last physical examination was on /or about _____mo. _____day _____yr.

☐ Yes ☐ No Has there been any change in your general health within the past year?
☐ Yes ☐ No Are you currently under the care of physician?
☐ Yes ☐ No Have you had any serious illnesses or operations?
If yes, what was the illness or operation?_____
☐ Yes ☐ No Have you been hospitalized or had a serious illness within the past five years?
If yes, explain_____

**Do you have or have you had any of the following diseases or conditions?**

☐ Yes ☐ No Rheumatic fever or rheumatic heart disease
☐ Yes ☐ No Congenital heart lesions
☐ Yes ☐ No Cardiovascular Disease* **If yes, please specify below.**
(☐ heart trouble, ☐ heart attack, ☐ coronary insufficiency, ☐ coronary occlusion,
☐ high blood pressure, ☐ arteriosclerosis, ☐ stroke)
***Cardiologist Name:_____ Tel: (_____)_____**
☐ Yes ☐ No Mitral Valve Prolapse/Heart Murmur
☐ Yes ☐ No Do you have pain in the chest upon exertion?
☐ Yes ☐ No Are you ever short of breath after mild exercise?
☐ Yes ☐ No Do your ankles swell?
☐ Yes ☐ No Do you get short of breath when you lie down, or do you require extra pillows at night?

| | |
|---|---|
| ☐ Yes ☐ No Allergies | ☐ Yes ☐ No Hives or skin rash |
| ☐ Yes ☐ No Asthma or hay fever | ☐ Yes ☐ No Sinus trouble |
| ☐ Yes ☐ No Arthritis | ☐ Yes ☐ No Inflammatory rheumatism (painful swollen joints) |
| ☐ Yes ☐ No Stomach ulcers | ☐ Yes ☐ No Kidney trouble |
| ☐ Yes ☐ No Low blood pressure | ☐ Yes ☐ No Fainting spells or seizures |
| ☐ Yes ☐ No AIDS or venereal disease | ☐ Yes ☐ No Hepatitis, jaundice, or liver disease |
| ☐ Yes ☐ No Tuberculosis | ☐ Yes ☐ No Do you have a persistent cough or cough up blood? |

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Do you have to urinate (pass water) more than 6 times a day?
☐ Yes ☐ No Are you thirsty much of the time?
☐ Yes ☐ No Does your mouth frequently become dry?
☐ Yes ☐ No Have you undergone surgical replacement of any joints (eg. artificial knee or hip) or heart-related surgery?
If yes, please explain_____
☐ Yes ☐ No Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
☐ Yes ☐ No Generally, are you in good health?
☐ Yes ☐ No Do you have a blood disorder like anemia?
☐ Yes ☐ No Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth?

NJC?QC NPMTGBC L?KC ?LB RCJ# MD WMSP NF?PK?AW8 _____

_____

☐Yes ☐No Are you taking any drugs or medications? If yes, please include below or list separately:

***Please checkmark the following medications which you are currently taking and/or have taken:***

☐Antibiotics, ☐Sulfa drugs, ☐Anticoagulants (blood thinners), ☐Medicine for high blood pressure, ☐Cortisone (steroids), ☐Tranquilizers, ☐Antihistamines, ☐Aspirin, ☐Insulin, ☐Tolbutamide (Orinase) or similar drug, ☐Digitalis or drugs for heart trouble, ☐Nitroglycerin, ☐Other _____

_____

_____

***Please checkmark if you are allergic or have reacted adversely to:***

☐Local anesthetics, ☐Penicillin or other antibiotics, ☐Sulfa drugs, ☐Latex, ☐Barbiturates, ☐Sedatives or Sleeping pills, ☐Iodine, ☐Codeine or other narcotics _____

_____

☐Yes ☐No Have you had any serious trouble associated with any previous dental treatment?

If yes, explain_____

☐Yes ☐No Do you require premedication prior to dental treatment that you are aware of?

If yes, explain_____

☐Yes ☐No Do you have any disease, condition, or problem not listed above, that you think I should know about?

If yes, explain_____

☐Yes ☐No Are you employed in a situation which exposes you regularly to x-rays or other ionizing radiation?

☐Yes ☐No Are you wearing contact lenses?

☐Yes ☐No Are you a smoker?
☐Yes ☐No Do you suffer from sleep apnea?
☐Yes ☐No Do you snore, or has anyone told you that you do?
☐Yes ☐No Do you clench or grind your teeth at night?

How would you rate your smile on a scale from 1 (worst) to 10 (best)? _____

If you could, how would you change your smile?_____

_____

Women: ☐Yes ☐No Are you pregnant?
☐Yes ☐No Do you have problems with your menstrual period?

# FINANCIAL POLICY

We are committed to providing you with the best possible 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, DEBIT CARDS, VS/MC, AMEX, AND DISCOVER.**

**ADULT PATIENTS -** Adult patients are responsible for full payment at time of service.
**MINORS ACCOMPANIED BY AN ADULT -** The adult accompanying a minor, and his/her parents (or guardians), are responsible for full payment at the time of service.
**UNACCOMPANIED MINORS -** The parents (or guardians) are responsible for full payment. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or to credit card, or paid by cash or check at time of service.

## REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. We will not accept insurance on your first visit unless special arrangements were made; however, we will complete your claim form so that you can be reimbursed by your insurance company to the extent of your coverage. On subsequent visits, we MAY accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, YOU MUST PAY THE PERCENTAGE NOT COVERED BY YOUR INSURANCE.

Please note that any insurance payment estimates provided as part of your treatment plan are solely estimates generated by our practice management software. These are **NOT** guarantees of payment. For more accurate information on insurance payment towards any specific treatment, you may inquire directly with your insurance carrier or request the processing for a pre-determination of benefits. Please understand that most insurance carriers will also not guarantee benefits presented in a pre-determination, and this process will often delay treatment for several weeks. If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

Insurance is a contract between you and your insurance company. We are not a party to this contract in most cases; therefore, you are solely responsible for your benefits and eligibility information. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

## DELINQUENT ACCOUNTS

Late Payment Charges (1.5% per month) are added to unpaid accounts after 60 days from date of service. In the case of default of your account you will pay collection costs, interest on the unpaid balance until paid in full, and attorney's fees incurred in attempting to collect on your present and future account balance. Collection accounts may be reported to credit service bureaus, when appropriate.

## MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

**Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.**

*By signature below, I accept the terms of this Financial Policy and I authorize release of any information relating to a claim, to all of my insurance companies, as warranted. I further authorize payment on a claim directly to the doctor, unless alternate arrangements have been previously made. My signature also applies to all dependents listed on my account.*

***Patient Name(s):_____ Guarantor Name_____***

***Guarantor signature_____ Date_____***

**Krause Comprehensive Dental Care LLC**
**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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03 / 26 /2013 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**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 if 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.

***Our Privacy Official: Diane Krause, Office Manager ● Telephone: 973-334-5556 ● Fax: 973-331-0134 ● E-mail: office@kcdcmontville.com***
***Address: 150 River Road Bldg. J2, Montville, New Jersey 07045***

# HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

**I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

- **Aid in the implementation of treatment and healthcare operations.**
- **Conduct, plan and direct my treatment and follow-up care, as warranted, among the multiple healthcare providers who may be directly or indirectly involved in that treatment.**
- **Correspond with and/or obtain payment from designated third-party payers.**

**I have been presented with a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.**

**I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.**

**I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.**

**Krause Comprehensive Dental Care**
**150 River Road**
**Building J, Suite 2**
**Montville, New Jersey 07045**
**973-334-5556**

By signature below:

- I attest to have carefully read and completed all personal, medical history, and insurance information accurately and to the best of my knowledge.

- I agree that I have read, understand, and will comply with the terms as outlined in the Financial Policy for Krause Comprehensive Dental Care.

- I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and acknowledge all disclosures relative to my treatment by Krause Comprehensive Dental Care.

_____ _____/_____/_____

***Patient Name*** ***Date of Birth***

_____

***Patient Signature (18 yrs. and older)***

_____ _____

***Responsible Party Signature, if Minor*** ***Today's Date***

_____

***Relationship to Patient***