DENTAL REGISTRATION AND HEALTH HISTORY

DATE____________________

Patients Name____How do you prefer to be addressed?________________________

Mailing Address ______________________________City ____________________ State ________ Zip ________

Sex: M F Age:______ Birth date: ________ Single Married Widow Separated Divorced SS# ____________________

Home Phone Number: ☐ ______________ Cell Phone Number: ☐ ______________ Work Phone Number: ☐ ______________
(Please Check Primary Number)

Occupation: ______________________________ Employer: ______________________________

Employer's Address: ______________________________ City ____________________ State ____________

If Student, name of School / College: ______________________________ City ______________ State ________ PT Full

Whom may we thank for referring you to our office: ____

Email Address: ____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party ______________________________ Relationship to Patient ____________________

Mailing Address ______________________________City ____________________ State ________ Zip ________

Sex: M F Age:______ Birth date: ________ Single Married Widow Separated Divorced SS# ____________________

Home Phone Number: ______________________________ Work Phone Number: ______________________________

Occupation: ______________________________ Employer: ______________________________

Employer's Address: ______________________________ City ____________________ State ________ Zip ________

INSURANCE INFORMATION

Policy Holders Name ______________________ Relationship to Patient ______________ SS # ________DOB ________

Name of Employer ______________________ Employee Address ______________________ State ________

Insurance Co. ______________________ Group # ______________ Address ______________________

Secondary Insurance Information

Policy Holders Name ______________________ Relationship to Patient ______________ SS # ________DOB ________

Name of Employer ______________________ Employee Address ______________________ State ________

Insurance Co. ______________________ Group # ______________ Address ______________________

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? **Yes** **No**
   If yes, which family member (s)?____
2. Date of last physical examination ______________ Physician's Name ______________________
3. Date of last dental examination ______________ Date of last dental x-rays ______________________
4. Previous Dentist's name ______________________City/State ______________________
5. Are you having pain or discomfort at this time? **Yes** **No**
6. Do you feel nervous about having dental treatment? **Yes** **No**
7. Have you ever had a bad experience in a dental office? **Yes** **No**
8. Is there anything you dislike about your smile? **Yes** **No**
9. Is there anything you would like to speak with the Doctor about in private? **Yes** **No**
10. Have you been a patient in the hospital during the past two years? **Yes** **No**
11. Have you been under the care of a medical doctor during the past two years? **Yes** **No**
12. Have you taken any medications or drugs in the past two years? **Yes** **No**
13. Are you taking any vitamins, herbal supplements or "cures"? **Yes** **No**
14. Have you ever had any excessive bleeding requiring special treatment? **Yes** **No**

ALLERGIES

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other: ___________

MEDICATIONS

Please list medications you are currently taking:
____
____
____

Pharmacy :______________________________________

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

Condition			Condition			Condition		
Chest Pain	**Yes**	**No**	Shortness of Breath	**Yes**	**No**	Hives or skin rash	**Yes**	**No**
Heart Failure	**Yes**	**No**	Ulcers	**Yes**	**No**	Alcoholism	**Yes**	**No**
Heart Disease or Attack	**Yes**	**No**	Mental Retardation	**Yes**	**No**	Herpes	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Emphysema	**Yes**	**No**	Glaucoma	**Yes**	**No**
Heart Problems	**Yes**	**No**	Fainting or dizzy spells	**Yes**	**No**	*Steroid Treatment	**Yes**	**No**
Liver Disease	**Yes**	**No**	Eating Disorder	**Yes**	**No**	Arthritis	**Yes**	**No**
Heart Surgery	**Yes**	**No**	Epilepsy or seizures	**Yes**	**No**	*Any type of implant	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Persistent Cough	**Yes**	**No**	Dentures or Partials	**Yes**	**No**
*Heart Murmur	**Yes**	**No**	Tuberculosis (TB)	**Yes**	**No**	Birth defects	**Yes**	**No**
*Rheumatic Fever	**Yes**	**No**	Asthma	**Yes**	**No**	HIV Positive, ARC, AIDS	**Yes**	**No**
Psychiatric treatment	**Yes**	**No**	*Congenital Heart Problems	**Yes**	**No**	Hay fever	**Yes**	**No**
Sickle Cell Disease	**Yes**	**No**	Hepatitis A (Infectious)	**Yes**	**No**	Use of tobacco products	**Yes**	**No**
Sinus trouble	**Yes**	**No**	Hepatitis B (Serum)	**Yes**	**No**	Bruise easily	**Yes**	**No**
*Artificial joints	**Yes**	**No**	Hepatitis C or other	**Yes**	**No**	Jaundice	**Yes**	**No**
Thyroid Disease	**Yes**	**No**	Heart pacemaker	**Yes**	**No**	Heart Surgery	**Yes**	**No**
Anemia	**Yes**	**No**	Stroke	**Yes**	**No**	Kidney Trouble	**Yes**	**No**
Blood transfusion	**Yes**	**No**	Drug addiction	**Yes**	**No**	Hemophilia	**Yes**	**No**
*Any type of transplant	**Yes**	**No**	Cold Sores	**Yes**	**No**	Diabetes	**Yes**	**No**
*Mitral Valve Prolapse	**Yes**	**No**	Radiation Therapy	**Yes**	**No**	Chemotherapy	**Yes**	**No**
						Cancer (type:)	**Yes**	**No**

***Antibiotic pre-medication may be required prior to your appointment.**

Have you ever experienced any of the following problems with your jaw:

Clicking	**Yes**	**No**
Pain in or around your ears ?	**Yes**	**No**
Difficulty opening or closing	**Yes**	**No**
Difficulty chewing	**Yes**	**No**
Do you have a history of trauma to your jaw?	**Yes**	**No**
Have you ever been diagnosed with TMJ/TMD?	**Yes**	**No**

Do you have currently have any problems listed below?
Please circle all that apply:

Swelling	Bad Taste
Bleeding Gums	Loose Teeth

Sensitive to:

Hot	Cold
Biting/Pressure	Sweets

Other: ______________________________

Do you have any sores, lumps or growths in or near your mouth?	**Yes**	**No**
Have you ever had difficult extraction's in the past?	**Yes**	**No**
Have you ever had prolonged bleeding following extraction's?	**Yes**	**No**
Are there now any growths or sores in or around your mouth?	**Yes**	**No**
Do you habitually clench or grind your teeth during the day or night?	**Yes**	**No**

Problem with bad breath? (Halitosis)	**Yes**	**No**
Do you have any trouble chewing?	**Yes**	**No**
Does food collect between your teeth?	**Yes**	**No**
Have you ever had instructions in oral hygiene ?	**Yes**	**No**
Have you ever taken Redux or Pondimin (Fen Phen) ?	**Yes**	**No**

Have you ever been told you have gum problems?	**Yes**	**No**
Have you ever needed to see a periodontist ?	**Yes**	**No**
Do you now have bleeding gums or any other gum condition?	**Yes**	**No**
Is there anything related to your medical or dental history that you have not indicated above ?	**Yes**	**No**

If yes, please explain: ____

WOMEN: Are you pregnant now?	**Yes**	**No**
Are you currently breast feeding?	**Yes**	**No**
Are you taking oral contraceptives?	**Yes**	**No**

If yes, what is your due date? ________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise pay able to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient or guardian

Michael T. Ward D.M.D.
61 Newton Sparta Road | Newton NJ, 07860 | (973) 383-7200

Written Financial Policy

Thank you for choosing Dr. Michael Ward. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Arrangements:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Dr. Michael Ward requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Assignment of benefits: I authorize release of any information relating to my dental claims. I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.______________________________________

Dr. Ward charges $12 for returned checks. For accounts referred to a collection agency there is a fee of 35% added to the account balance.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2]Subject to credit approval. [3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Dr. Michael T. Ward DMD
61 Newton Sparta Rd.
Newton, NJ 07860
973-383-7200
Fax 973-383-0131

Informed Consent

Potential Risks and Limitations of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to insure the best possible care.

Throughout life teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare up during any dental treatment, and may require endodontics (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

Informed Consent

I understand that during treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high-speed dental equipment.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Excellent oral hygiene
2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification: who are constantly late for their appointments: who continue to excessively cancel their appointments: who fail to practice acceptable oral hygiene: or who are uncooperative with staff providing care. ***A fee of $25 will be charged for last minute cancellations. A fee of $50 will be charged after 3 “no show” appointments.***

Signature_____________________________________

Date_______________________

Michael T. Ward D.M.D.
61 Newton Sparta Rd.
Newton NJ, 07860
973-383-7200

Notice of Privacy Practices

Date:______________________

Patient Name:________________________

Date of Birth:_________________________

I have received/reviewed this notice of Privacy Practices written and displayed in plain language. This notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. Including appeals of utilization management determinations, electronic submission of claims, xrays and photos.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at or controlled by this practice.

I give permission to leave appointment information by (circle one or more):

Mail email home phone work phone cell phone

I give permission to leave medical results/ information by (circle one or more):

Mail email home phone work phone cell phone

I give permission for the following people to have access to my medical information:

____

____

___contact# ____

Your Signature:____