Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY DATE

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	YES	NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	YES	NO
DO YOU HAVE A FEVER?	YES	NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	YES	NO
DO YOU HAVE A DRY COUGH?	YES	NO
DO YOU HAVE A RUNNY NOSE?	YES	NO
DO YOU HAVE A SORE THROAT?	YES	NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	YES	NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	YES	NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	YES	NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	YES	NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	YES	NO

IF SO, WHERE?

DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

HAMILTON FAMILY DENTAL, PA
4450 Black Horse Pike, Suite 3957
Mays Landing, NJ 08330
Telephone: (609) 909-1100
Fax: (609) 909-9199

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

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

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

☐ Aspirin	☐ Sulfa
☐ Barbiturates (Sleeping pills)	☐ Latex _____
☐ Codeine	☐ Other _____
☐ Local Anesthetic	_____
☐ Penicillin	

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT
HAMILTON FAMILY DENTAL, P.A

Suite 3957- The Festival at Hamilton
Mays Landing, New Jersey 08330
(609) 909- 1100

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:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you, as well as received, read and understand 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 in 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 above to obtain a current copy of the Notice of Privacy Practices

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

I understand that I may revoke this consent in writing at any time, expect to the event that you have taken action relying on this consent

Patients Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Dear Patients,

Our office is dedicated to providing the highest quality of dental care possible to our patients.

Therefore, Hamilton Family Dental will no longer be offering amalgam ("silver") fillings to our patients. We will only place composite ("white") fillings.

Our doctors prefer composite fillings for a number of reasons. Composite fillings restore the natural color back to the tooth, require less removal of natural tooth structure, have less post-operative sensitivity to hot and cold, and can actually bond the tooth restoring most of the original strength back to it.

Although we realize there is an increased cost to our patients, we feel like the quality of dental care associated with composite fillings greatly outweighs the added cost incurred.

We take pride in always offering our patients leading edge technology with caring and professional attitude. We will only recommend what is best for your dental health and what we would provide to ourselves and to our families.

Patient/Guardian Signature: _____

Date: _____

Missed Appointment/ 24 Hour Notice Policy

Hamilton Family Dental P.A
Suite 3957 Black Horse Pike
Mays Landing, NJ 08330
609-909-1100

The staff at Hamilton Family Dental is committed to providing quality care to our patients. We believe it is very important to keep your dental health on track. Our physicians strive to see patients in a timely matter. We respect your time and ask that you respect our time and other patient's needs by keeping your appointment. Please keep in mind that each missed appointment is not just time lost, but also time when other patients can not be seen.

It is your responsibility to provide us with a working telephone number to allow us to communicate important information such as providing reminders of scheduled appointments. We call 48 - 24 hours in advance to confirm your appointment. If we can not reach you to confirm that you will be here, your appointment may no longer be available. We require you give us at least 24 hours notice to cancel an upcoming appointment. Any cancellation not made at least 24 hours before your scheduled appointment is considered a missed appointment and you will be charged a fee of $40.00.

If you arrive 20 minutes late for your appointment without prior notification to our office this may also be considered a missed appointment depending on if your provider still has time remaining within your scheduled appointment to perform your treatment. We know that unexpected demands can arise, and we certainly understand how such circumstances can interfere with your ability to keep your dental appointment, but please remember that communicating with our office is critical to us providing you with quality dental care.

We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will make every attempt to let you know the status of our schedule. We appreciate your cooperation and look forward to serving your dental needs.

I have read and understand the policy put in place by Hamilton Family Dental.

Signature of Patient: _____

Relationship of Patient: _____

Date: _____

Dear Patients:

Please be advised that all copays are estimated from what YOUR insurance companies give us to go by. Most insurance companies downgrade many procedures including fillings (white to silver), crowns, root canals, bridges, dentures, and implants. The only TRUE estimate would be to send a pre-authorization so we know exactly what is covered. Please be aware of your dental benefits and coverage. Our front desk does their best to estimate exactly what the copays are but unfortunately no benefits are guaranteed without a pre-authorization. If you have any questions, contact your insurance company so they can better assist you with exactly what your plan covers.

Signature_____

Printed name _____

Date_____

Hamilton Family Dental
3957 Black Horse Pike
Mays Landing, NJ 08330
(609) 909 - 1100

Repair/Replacement Policy

For Dental Implants, Veneers, Permanent Crowns & Bridges
Policy applies to initial date of service

0-1 years	office 100% patient 0%
1-2 years	office 80% patient 20%
2-3 years	office 60% patient 40%
3-4 years	office40% patient 60%
4-5 years	office 20% patient 80%
5+ years	usual fees

This policy is **VOID** if you are a tobacco user. If you quit smoking/use of tobacco successfully at least three before surgery, please see us for a contract to ensure a standard implant policy. The policy will be **VOID** if smoking/use of tobacco is restarted at any point after quitting.

This policy is **VOID** if x-rays, exams or other diagnostic material are refused; if recommended treatment or recare visits are delayed or declined by the patient; or if home care is either grossly inadequate or routinely fair to poor. It is **VOID** if a medical condition or accident is the major contributing factor for failure. Excludes IV sedation, extractions, or grafting.

Your health and well being are important to Dr. Podolnick, Dr. Moosavi, and their team. After undergoing a surgical procedure such as a dental implant, it is imperative that these fixtures be monitored. Therefore, to insure proper health, Dr. Podolnick and Dr. Moosavi recommend that they see you for an evaluation and yearly radiographs. We would be delighted to follow up with you here at our office and offer you a hygiene appointment with our dental hygienists. If you prefer to be seen by another dentist a report will be necessary. This will allow us to continue the warranty of your implant.

I have read and understand the above policy.

_____
Print Name

_____
Signature/Date

_____
Witness/Date

General Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.
Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.
Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations, Preventive Services, Diagnosis, Basic Restorative and Crowns:
Patient Initials: _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Patient Initials:** _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. **Patient Initials**: _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. **Patient Initials**: _____

Print Patient Name:

Patient Signature **Date**