Thurm Dental Group

Keeping the community in smiles

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State of New Jersey General Anesthesia Permit # 473

Patient information form: Date __/__/____

Patient name: _____ M / F (Circle one) Birthdate___/___/___ Age ___

Address: Street_____ City_____ State___Zip_____

Home Phone: (__)_____ Cell Phone: (__)_____Work Phone: (___)_____

Emergency Contact: _____Relation: _____Phone: ( )_____

Email Address: _____Social Security Number: _____/___/_____

Referred by:_____

Employer: _____Occupation: _____

Dental insurance information:

Are you covered by dental insurance? **Y/N**

Subscriber Name: _____Subscriber's Date of Birth: _____/___/____

Relation to patient: _____Insurance Company: _____

Member ID: _____Group ID: _____

Who is responsible for this bill?_____

Payment type for today? Cash __ Check___ Credit Card___ Care Credit____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account and any professional services rendered. I certify the information is true, and correct to the best of my knowledge. I will notify you of any changes in my health status or personal information above.

Patient or Guardian signature _____ Date ___/__/_____

Patient or Guardian printed name _____Date __/___/_____

Medical history and General Health:

Are you in good health? **Y/N** if no please explain _____

Are you under medical treatment? **Y/N** If yes please explain: _____

History of Sleep Apnea or breathing disorders? **Y/N** If yes please explain _____

Do you take any blood thinners other than aspirin? **Y/N** if yes what medication? _____

Are you allergic to Penicillin? **Y/N** Latex? **Y/N** Any other allergies? **Y/N** if yes what? _____

_____

Women: Are you pregnant? **Y/N** Taking Birth control? **Y/N** (If yes antibiotics can counteract)

Have you ever taken drugs for osteoporosis? **Y/N** if yes when? What kind? _____

Do you require Pre-medication prior to dental treatment? Y/N If yes what kind? _____

Please circle Y/N to the following: Autoimmune disorder Y/N if yes please explain: _____

Heart Valve replacement? Y/N	Prosthetic Joint replacement? Y/N	Facial Radiation Therapy? Y/N
If yes when? _____	If yes When? _____	If yes When? _____
High Blood Pressure? Y/N	Last Blood Pressure ___/_____	Last Blood pressure date __/_/__
Afib? Y/N	Drug Addition Y/N	Convulsions/Epilepsy? Y/N
Diabetes? Y/N type 1 or 2	Semaglutide? Y/N	Epilepsy? Y/N
Low Blood Pressure? Y/N	Hepatitis? Y/N (type_____)	Dizziness or Fainting? Y/N
Stroke? Y/N	Emphysema/COPD? Y/N	Anemia or blood disorder? Y/N
Tuberculosis? Y/N	Arthritis? Y/N	Smoking/Tobacco? Y/N If yes how long?__
Marijuana Use? Y/N	Jaundice or Liver disease? Y/N	

Physician name and phone number: _____

Pharmacy name and phone number: _____

Patient Signature_____Date____/_____/_____

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Medication and supplements page

If no prescriptions or over the counter medication taken daily/regularly please check this box: ☐

Patient Name: ______________________________ DOB: ____________________

Medication:	Dosage:	Taken for:

Dental Information:

Have you been experiencing any pain recently? **Y/N** If yes please explain: _____

_____

What is your immediate concern? _____

Have you had any of the following? **Please circle Y or N, if yes please explain:**

A negative dental experience? **Y/N** _____

Trouble getting numb? **Y/N** _____

Any reaction to (local) or (general) anesthetic? **Y/N**_____

Have you ever been told you have periodontal or gum disease? **Y/N** If yes, when?_____

If yes did you have treatment?_____

Do you notice any bleeding when brushing or flossing? **Y/N**_____

Do you have dry mouth? **Y/N**_____

Do you have any loose teeth? **Y/N**_____

Do you have sensitivity to hot or cold foods or liquids **Y/N** _____

Do you ever wake up from pain at night? **Y/N**_____

Do you grind your teeth or clench? **Y/N**_____

Have you ever worn a nightguard appliance? **Y/N** _____

Are you uncomfortable or self-conscious about your smile? **Y/N**_____

If you could change anything about your smile what would it be?_____

_____

I certify that the information above is true. I also agree that if any of this information is to change I will notify Dr. Thurm and staff prior to the appointment beginning. I also understand that medical history is important to determine appropriate treatment.

Patient Signature: _____Date__/__/____

Patient Guardian: _____Date__/__/_____

About Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment for services is due at the time services are rendered, unless our staff have approved payment arrangements in advance. We accept cash, checks, and all major credit cards. We will be happy to help you process your insurance claim form for your reimbursement. Such requests must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits. Credit reports may be requested from a national credit reporting service for patients who assign insurance benefits or request extended payment plans.

Our office requires a credit card on file for processing payments, co-payments on insurance claims, and open balances. Please present your credit card to our receptionist to confirm expiration date and security code. Please note that any open claims or balances over 60 days after services are rendered will be charged to your credit card on file. Patients who cannot provide a credit card are required to pay for all services at the time of treatment.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5 % per month. If an attorney is retained to collect past due amounts on your account, you will be responsible for these additional fees. Charges will occur for broken appointments and appointments canceled without 24 hours advance notice. We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore covered up to the maximum determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "UCR" is defined as usual, customary, and reasonable for this region. Thus, our fees are considered UCR by most companies. Some companies set their own arbitrary fees which are much lower than UCR. This will result in a greater cost for the patient, and a lesser cost for the insurance company.

3. **Not all services are a covered benefit in all contracts. We must emphasize, that as dental care providers, our relationship is with you, not your insurance company. We will recommend the best possible treatment for you, regardless of your insurance coverage. As the patient, you should be aware of the limitations of your dental plan, but you should not let those limitations affect the quality of dental care you choose to receive.**

If you have any questions please do not hesitate to speak with myself or another member of my staff.

Please initial that you have read and understand the following: initials ____

Authorization for Submission of Claims and Assignment of Benefits

I authorize the health care provider above to submit claims for payment for services to the health care plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Insurance Company 1. _____

Insurance Company 2._____

_____

Name of Patient

_____

Signature of Patient, Parent or Guardian

Authorization for Release of Health Information

I authorize the health care provider named above to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives' any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain in effect for up to five years from this date.

I know that I have the right to receive a copy of this authorization if requested.

HIPAA Release Form

HIPAA Release Form Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document. Section II – Health Information I would like to give the above healthcare organization permission to: Tick as appropriate Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions. Or Disclose my complete health record except for the following information Mental health records Communicable diseases including, but not limited to, HIV and AIDS Alcohol/drug abuse treatment records Genetic information other (Specify)

_____

_____

_____

_____

Form of Disclosure: Electronic copy or access via a web-based portal Hard copy

Section III – Reason for Disclosure Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

Section IV – Who Can Receive My Health Information I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them. Section V – Duration of Authorization This authorization to share my health information is valid: Tick as appropriate a) From _____ to _____ Or b) All past, present, and future periods Or c) The date of the signature in section VI until the following event: _____ I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared, by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV. Page 3 of 3
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature Signature: _____ Date: _____
Print your name: _____ If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____
_____
_____
_____