PATIENT INFORMATION

Today's Date_____

First Name-_____ Last Name-_____ Middle Initial-_____

Address-_____

Home Phone-_____ Work Phone-_____ Cell Phone-_____

Date of Birth-_____ Age-_____ E-Mail-_____

Sex- Female - ☐ Male- ☐ /// Married- ☐ Widow- ☐ Single- ☐ Minor- ☐ Separated- ☐ Divorced- ☐ Partner for _____ Years

Spouse's Name-_____ Patient Employer / School-_____

Employer / School Address-_____ Occupation-_____

Who is responsible for this account-_____ Relationship to Patient_____

How were you referred to our office-_____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION-

Policy Holders Name-_____

Policy Holder ID/ SS#-_____Policy Holder's Date of Birth-_____ Group #-_____

Insurance Company Name, Address & Phone Number-_____

SECONDARY INSURANCE INFORMAITON-

Policy Holders Name-_____

Policy Holder ID/ SS#-_____ Policy Holder's Date of Birth-_____ Group #-_____

Insurance Company Name, Address & Phone Number-_____

ASSIGNMENT & RELEASE-

I certify that I, and / or my dependents(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. George Bork 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-names dentist 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 be in place until I further notice either given by myself or my personal representative.

Signature of Patient / Parent/ Guardian-_____

Print Name of Person Signing-_____

Date-_____Relationship to Patient-_____

DENTAL HISTORY

Reason For today's Visit-_____

Former Dentist-_____ City /State-_____ Date of Last Visit-_____

Please check Yes or NO- Bad Breath ☐ Yes ☐ No Bleeding Gums ☐ Yes ☐ No Blister on lips or mouth ☐ Yes ☐ No

Burning sensation tongue ☐ Yes ☐ No Clicking or popping of jaw ☐ Yes ☐ No Fingernail biting ☐ Yes ☐ No

HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name-_____Phone #- _____Date of last visit-_____

Are you under a physician's care now? ☐ Yes ☐ No If Yes-_____

Have you ever been hospitalized for had a major operation? ☐ Yes ☐ No If Yes-_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If Yes-_____

Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No If Yes-_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications? ☐ Yes ☐ No
containing Bisphosphonates? If Yes-_____

Are you on a special diet? ☐ Yes ☐ No If Yes-_____

Do you use tobacco? ☐ Yes ☐ No If Yes- Amount / Day-_____

**Women: Are you… *Pregnant or Trying to get Pregnant? ☐ Yes ☐ No *Nursing ☐ Yes ☐ No **

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlett Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hear Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding Abnormally	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
w/ extractions or surgery ----------		High Blood Pressure	☐ Yes ☐ No	Swollen Limbs	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Drug Addition	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or Growth	☐ Yes ☐ No
Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
COVID-19	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Cough Persistent / Bloody	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Stomach-Intestinal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Alzheimer's Disease	☐ Yes ☐ No	Anaphylaxis	☐ Yes ☐ No

Have you ever had any serious illness not listed ☐ Yes ☐ No-
If yes please explain- _____

MEDICATIONS

List any medications you are currently taking and correlating diagnosis: _____

_____

_____

_____

Pharmacy Name-_____ Location-_____ Phone #-_____

ALLERGIES

☐ Latex ☐ Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Local Anesthetic ☐ Penicillin

☐ Sulfa ☐ Iodine ☐ Other-_____

Financial Arrangements & Dental Insurance

We strongly feel our patients deserve the best possible dental care we can provide. Part of this care is a comfortable relationship between our team and you, the patient. In an effort to maintain this high quality of care we believe it is important to avoid misunderstandings. We have found that some misunderstandings have to do with insurance and our office's financial policy. Therefore we would like you to read the following information. If you have additional questions please feel free to ask one of our staff members.

Payment

Payment is due at the time services are rendered unless prior arrangements have been made with our staff. We accept cash, personal checks, money orders, Visa, MasterCard, Discover, American Express and in some cases CareCredit. A service charge of $30.00 will be added for returned checks. Balances over 60 days will incur a 1.5% service charge for each month the account is left unpaid. An additional charge of 20% of the total bill will be added if an account is not paid within 12 months and is sent to our collection agency. In order to avoid a broken appointment fee of $50.00 please be sure to contact the office 48 hours prior to the scheduled appointment time to inform us of your cancelation.

Dental Insurance

If you have dental insurance, we will be happy to process it for you if you supply us with all the necessary information. You can choose to assign your insurance benefits to Dr. Bork provided you complete and sign the assignment and release section of our blue form. We will then forward the claim to your insurance company for their possible payment towards services rendered. We **cannot** make these arrangements unless we have all the required information at the time of your visit. If we do not have the information, we require full payment at time of service.

Please note:

- Your insurance is a contract between you, your employer and the insurance company we are not a party to that contract. We are not responsible for any lack of plan benefits or determination of payments. The financial obligation for dental treatment is between you and our office. We work with your insurance as a courtesy to you, our patient.

- Our fees fall within the acceptable range by all insurance companies and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "usual, customary and reasonable" fees. **This does not apply** to companies who reimburse on an arbitrary standard cost of care (fee schedule).

- Not all services are covered by insurance. If you have any doubts about coverage, get a "predetermined cost" from your insurance company.

- Rarely does an insurance company pay 100% for all services rendered. Because of this, if we agree to accept assignment of benefits, we will then check with your insurance to get a brief explanation of benefits this will then give us an idea of how they will pay and then we may **estimate** what portion will be the responsibility of the patient and that portion will be due at the time services are rendered. **This is only an estimation of what may be uncovered by your insurance company**. If we receive a payment from your insurance that is higher than what we estimated, we promptly refund payments made by you for those same charges. If we receive less from your insurance, the remaining balance will need to be paid by you. If the services are not covered by your insurance for any reason at all, the entire amount will be payable by you.

Please complete below information

Date_____

Patient's Name_____

Address_____

Social Security Or ID#_____ **Date of Birth**_____

Who is financially responsible for payment on the above patients account?

Name_____

Address_____**(circle here if same as above)**

Social Security Or ID #_____

Employer_____

Spouse's Name_____

Spouse's Social Security Or ID#_____

Spouse's Employer_____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read all the information on this page and have completed the above. I certify this information is true and correct to the best of my knowledge.
I will notify Dr. George F. Bork's office of any changes in the above named patient's health status or the above information.

_____ _____

Signature of person responsible for the account **Date**

____ **Check here if patient is a minor and signature is the parent or guardian.**

Hampton Family Dental George F Bork, DMD One Manor Drive, Hampton, New Jersey 08827 (908) 537-4248

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____