

Progressive-Dentistry, LLC

Your Option ~ Your Choice

Jeffrey A. Oras, DMD

109 Main Street

Whitehouse Station NJ 08889

(908) 534-5140

PATIENT ACQUAINTANCE FORM

Patient's Name _____ Address _____

City _____ ST _____ Zip _____ Home Phone # _____

Cellphone #: _____ Email Address: _____

Sex: _____ Birthdate/Birthplace _____ Soc. Sec. #: _____

Marital Status: _____ Spouse's Name: _____ Spouse's Birthdate: _____

If a child, parent's name _____

In Case of Emergency, Notified: _____ Contact #: _____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Policy Subscriber: _____ Employer: _____

Employer Phone #: _____ Ins. Co Name: _____

Insurance Company Address: _____

Subscriber's Soc. Sec. #: _____ Group #: _____ Ins. Co Phone #: _____

PLEASE GIVE SECONDARY INSURANCE INFORMATION TO OUR RECEPTIONIST.

How were you referred to our practice? _____

Are you here for a short term fix or a long term solution? _____

Yes No

_____ 1. Do you have any dental conditions requiring treatment today? _____

_____ 2. Have you been treated by a physician within the past year? _____

_____ 3. Has there been any change in your health in the past year? _____

_____ 4. Are you allergic to any medications, dairy or milk products?

If so, please list: _____

_____ 5. Has any physician or dentist asked you to take an antibiotic just prior to your dental visit?

If so, please list: _____

Does Your Medical History Include Any of the Following Conditions? (CHECK/CIRCLE WHICH APPLY)

_____ Surgical procedures, including cosmetic procedures, within the last 5 years

_____ Rheumatic Fever

_____ Heart Murmur/ Mitral Valve Prolapse

_____ Heart Attack/ Heart surgery/ Pacemaker

_____ Artificial Valves

_____ High or Low Blood Pressure (**please indicate**)

_____ Respiratory Disease/Asthma

_____ Diabetes

_____ Tumors/Growths/ Cancer

_____ Radiation or Chemotherapy

_____ Bleeding or Anemia problems

_____ Other blood disorders? If so, please list. _____

_____ Tuberculosis

_____ Ulcers

_____ Rheumatism

_____ Arthritis

_____ Stroke

_____ Dizziness

_____ Epilepsy

_____ Fainting Episodes

_____ Head Trauma/Disorders

_____ Mental Disorders

_____ Jaw Problems TMJ/TMD

(Medical History Continued – (PLEASE CHECK/CIRCLE WHICH APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Artificial bones/joint/hip replacements | <input type="checkbox"/> Stomach or Intestinal Disease |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Venereal Disease/ Herpes/ Canker sores |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Hepatitis A, B or C (please identify) |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> HIV, AIDS or AIDS Related Syndrome |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Are you pregnant or nursing? |
| <input type="checkbox"/> Do you smoke? _____
If so, how much per day? _____ | <input type="checkbox"/> Do you drink alcohol? _____
If so, how much per day? _____ |

Dental Questions: (YES or NO)

- _____ 1. Have you ever had a complete series of dental x-rays (approx. 20) taken?
If so, when? _____ by whom? _____ may we obtain them? _____
- _____ 2. Have you ever had a severe toothache?
- _____ 3. Have you ever had treatment for your gums?
- _____ 4. Do you want to improve the appearance of your teeth?
- _____ 5. Do your gums bleed or hurt when you brush them?
- _____ 6. Have you been aware of any bad odor or taste in you mouth?
- _____ 7. Are your teeth sensitive to heat, cold, or sweets?
- _____ 8. Do any of your teeth hurt when you chew?
- _____ 9. Have your teeth moved or drifted from their normal position?
- _____ 10. Do you grind or clench your teeth during the day, or night?
- _____ 11. Do you ever get pain in the jaw joint or frequent headaches?
- _____ 12. Have you ever noticed popping or clicking in your jaw joint?
- _____ 13. Do you consent to diagnostic photographs (X-rays)?

List Any Drugs/Medications/Supplements That You Are Presently Taking:

A Message About Our Practice

We have been serving the dental needs of our patients since 1990. We take great care in offering individualized treatment. The entire staff works in harmony to complement the needs of our patients while establishing a relationship of trust, ensuring a pleasant experience.

We would like to introduce you to our staff: As our practice grows, additional staff will join us to help serve your needs. Since, we all work together utilizing our special skills, throughout the course of your dental care, you may interact with:

- Jeffrey Oras, D.M.D - General Dentist
- Marie Oras – Office Manager/Dental Assistant
- Kristin Belcastro – Registered Dental Assistant
- Jean Evers, R.D.H. - Dental Hygienist
- Ashley Morin, R.D.H. – Dental Hygienist
- Beverly Ricci – Practice Administrator

If there are any concerns, questions, or comments that you have while in the practice please let us know so we may help meet your expectations.

OUR FINANCIAL POLICY:

Payment is due the time services are rendered (unless prior arrangements have been agreed upon). This includes insurance co-payments and deductibles.

Our billing statements are sent out monthly. **Our office reserves the right to charge balances older than 60 days a finance charge at the rate of 1.5% per month (18% annually). Additionally, our office reserves the right to charge returned check fees.**

In order to make payment for services as convenient as possible, we offer the following payment options:

- 1) Cash, Check or Credit Card (Mastercard / Visa / Discover / AMEX).
- 2) Care Credit: a flexible, monthly payment plan, which offers either a no interest or low interest plan with no down payment, no annual fees or prepayment penalties. (Applications are available at our front desk.)

Other financial options can be discussed based on the complexity of the treatment plan.

Our office reserves the right to charge for making and sending copies of a patient's information, including X-rays.

Our office reserves the right to charge for broken appointments, or cancelled appointments without 24-hour advance notice.

PATIENT'S WITH INSURANCE:

As a courtesy, our office will promptly submit all claim forms for both in-network and out-of-network companies. Your insurance coverage is not a substitute for our professional fees, therefore, anything not covered by the insurance is ultimately the patient's responsibility. **Some out-of-network carriers (such as Horizon and United Healthcare/Oxford) will not reimburse our office directly. In those cases, payment must be made in full for services, at the time they are rendered. We will submit the insurance claims immediately for reimbursement directly to the patient.**

Upon your signature of this form, our office will accept an assignment of benefits from your insurance company with the following provisions: **(NOTE: Assignment of benefits does not mean payment in full.)**

- All deductibles and co-payments are due at the time of service.
- We will perform routine insurance verification of benefit coverage. However, if your claim is denied for type of plan coverage, you will be responsible for the full amount of treatment. The patient is responsible for confirming their individual plan coverage, as well as reviewing all the Explanation of Benefit documents provided by your insurance company. A pre-determination can be made to your insurance company once your treatment plan has been established.
- We will provide all necessary documentation your insurance company requests to process all dental claims. We will not enter into any dispute with your insurance company over any claims denied because of contractual benefits. We do not guarantee that your insurance company will cover all treatment that you receive from our office. Employer coverage plans may vary. Treatment is based on need and not by type of insurance coverage.
- If your insurance payment is not received within 60 days from the time of billing, we ask that you pay the balance due and seek reimbursement from your insurance company.
- Accounts 90 days past due maybe forwarded to collections.

We are committed to providing you with the best possible dental care, using the highest quality dental materials, making your visit the most positive experience in dental care

RESPONSIBLE PARTY:

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Signature _____ Date _____