FAIR LAWN
DENTAL ASSOCIATES

PATIENT REGISTRATION FORM

25-15 Fair Lawn Avenue
Fair Lawn, NJ 07407
admin@fairlawnsmiles.com
201-797-8464
201-797-6882
fairlawnsmiles.com

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Last name | First name | Middle Initial | Soc. Sec. #

Address | City | State | Zip Code

Cell phone | Home phone | Email address

Birthdate

Sex: ◯ M ◯ F Marital Status: ◯ Single ◯ Married ◯ Widow/Widower ◯ Divorced ◯ Separated

Patient Employed by | Occupation

Business Address | City | State | Zip Code

Business Phone

Whom may we thank for referring you?

Notify in case of emergency | Home phone | Cell phone

Primary Insurance

PERSON RESPONSIBLE FOR ACCOUNT

Last name | First name | Middle Initial | Relation to Patient

Birthdate | Soc. Sec. # | Home phone | Cell phone | Email address

Address **(if different from patient)** | City | State | Zip Code

Person Responsible Employed by | Occupation

Business Address | City | State | Zip Code

Business Phone

Insurance Company | Phone

Member ID/Policy # | Group #

Name of other dependents under this plan

Additional Insurance

Is patient covered by additional insurance? ◯ Yes ◯ No

Subscriber Name | Relation to Patient | Birthdate

Address **(if different from patient)** | City | State | Zip Code

Cell phone | Home phone | Email address

Subscriber Employed by | Business Phone

Insurance Company | Phone

Member ID/Policy # | Group #

Name of other dependents under this plan

Dental History

What would you like us to do today? | Are you in dental discomfort today? ◯ Yes ◯ No | Former Dentist

Phone | Email | Date of last dental care | Date of last x-rays

Check ☑ Yes or No if you have had problems with any of the following:

Y	N		Y	N		Y	N	
◯	◯	Bad breath	◯	◯	Grinding or clenching 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 mouth

How often do you brush? | Floss? | How do you feel about the appearance of your teeth?

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ◯ Yes ◯ No

Other information about your dental health or previous treatment _____

Medical History

Physician's name | Phone | Date of last visit

Have you had any serious illnesses or operations? ◯ Yes ◯ No If yes, describe: _____

Are you currently under physician care? ◯ Yes ◯ No If yes, describe: _____

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

Have you ever taken Fen-Phen/Redux? ◯ Yes ◯ No

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ◯ Yes ◯ No

Women: Are you pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking birth control pills? ◯ Yes ◯ No

Check ☑ Yes or No whether you have had any of the following:

Y	N		Y	N		Y	N	
◯	◯	AIDS/HIV Positive	◯	◯	Food allergies	◯	◯	Nervous problems
◯	◯	Anaphylaxis	◯	◯	Glaucoma	◯	◯	Pacemaker/ Heart surgery
◯	◯	Anemia	◯	◯	Headaches	◯	◯	Psychiatric care
◯	◯	Arthritis, Rheumatism	◯	◯	Heart murmur	◯	◯	Rapid weight gain or loss
◯	◯	Artificial heart valves	◯	◯	Heart problems	◯	◯	Radiation treatment
◯	◯	Artificial joints	**Describe:**			◯	◯	Respiratory disease
◯	◯	Asthma				◯	◯	Rheumatic/Scarlet fever
◯	◯	Atopic (allergy prone)				◯	◯	Shingles
◯	◯	Back problems				◯	◯	Shortness of breath
◯	◯	Blood disease				◯	◯	Skin rash
◯	◯	Cancer	◯	◯	Hemophilia/Abnormal bleeding	◯	◯	Spina Bifida
◯	◯	Chemical dependency	◯	◯	Herpes	◯	◯	Stroke
◯	◯	Chemotherapy	◯	◯	Hepatitis	◯	◯	Surgical implant
◯	◯	Circulatory problems	◯	◯	High blood pressure	◯	◯	Swelling of feet or ankles
◯	◯	Cortisone treatments	◯	◯	Jaw pain	◯	◯	Thyroid disease or malfunction
◯	◯	Cough, persistent	◯	◯	Kidney disease or malfunction	◯	◯	Tobacco habit
◯	◯	Cough up blood	◯	◯	Liver disease	◯	◯	Tonsillitis
◯	◯	Diabetes	◯	◯	Material allergies	◯	◯	Tuberculosis
◯	◯	Epilepsy			(Latex, Wood, Metal, Chemicals)	◯	◯	Ulcer / Colitis
◯	◯	Fainting	◯	◯	Mitral valve prolapse	◯	◯	Venereal disease

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status,I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature

Date

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THIS NOTICE DESCRIBES HOW MEDICAL YOU USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in arty form, whether electronically, on paper, or orally, are kept property confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and heath care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, dose personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove It.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feet that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more Information:

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257, Toll Free: 1-877-696-6775

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CONSENT AND NOTICE OF PRIVACY PRACTICES

TEXT MESSAGES

I, _____, consent to Fair Lawn Dental Associates using my cell phone to (choose one or both) ☐ Call or ☐ Text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include area code): _____

Signature _____ Date _____

EMAIL COMMUNICATIONS

I consent to receiving from Fair Lawn Dental Associates email communications regarding treatment, insurance, special promotions and my account. I understand that I can withdraw my consent at any time.

My email address is: _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received and reviewed a copy of this office's Notice Privacy Practices, our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

Signature _____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual Refused to sign
☐ Emergency Situation
☐ Communications Barrier
☐ Other: _____

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Welcome to our office! Drs. Azita and Arash Baseri provide you with the best available treatment options and manage your dental health with dedicated and professional care.

Although we are not contracted as an "in network" provider with some insurance carriers, we are happy to submit a claim to your insurance provider. We will also be your advocate to help seek the maximum allowable dental benefits regardless of the plan.

You are financially responsible for the cost of your treatment regardless of whether it is covered by insurance.

If you are not covered by insurance by insurance, we can help. There may be payment plans or financing options available to you. Please tell us about any concerns prior to your treatment so that we can help you find the best solution.

In consideration of dental treatment to be rendered to me or my dependents, I agree to sign over every dental benefit payment issued to me for dental services performed by this office within ten business days after receipt from a Dental Service Corporation, Health Service Corporation or Dental Plan Corporation. However, if the amount owed to this office is less than the amount of the dental benefit payment, then only the balance owed shall be paid.

Print your name: _____

Signature _____ Date _____