Dear Friend,

Thank you for choosing me as your general dentist. I will personally do everything possible to deserve your trust. I see this as the beginning to a great relationship.

It is important that you know I treat each patient one at a time to give the utmost attention and care, giving time to listen to your concerns and make an accurate diagnosis to your problem. I also look forward to partnering with you to achieve and maintain a beautiful healthy smile.

I do realize that dental emergencies can be stressful when they happen to you or someone you love. To help alleviate some of your concern, I promise to respond to your telephone calls promptly.

In today's busy world I understand the frustration to sit in a waiting room past the time of your appointment. My staff and I are dedicated to do our best to get you started on time for your scheduled appointment.

As your dentist, I realize it is my responsibility to keep up with the latest developments in cosmetic and restorative dentistry. That is why I take continuing education courses and retain active membership in several professional dental organizations.

But even more important than all of my training and experience, is the 100 plus years experience that my staff and I have collectively in the field of dentistry. I am very proud of our dental team and the many years we have been together helping our patients feel comfortable and cared for in our office.

So why do I do these things? The answer is simple. I want to build a lasting relationship with you. It is my goal that when you come to see me you'll feel really good about every aspect of your experience and happy that you chose me for your dental care.

Sincerely,

DawnMarie DiGrazia, D.M.D

Welcome to Somerset Dental Arts

279 E. Main Street
Somerville, NJ 08876
908-722-2999

Patient Name_____ Birth Date_____ Date_____

Cell Phone_____ Home Phone_____ Work/Other_____

Social Security #_____ Email_____

Address_____ City_____ State_____ Zip_____

Patient Employer/School_____ Phone_____

Emergency Contact_____ Relation_____ Phone_____

Whom may we thank for referring you? _____

Dental Insurance:

Name of Carrier_____ Subscriber's Name_____

Birth Date_____ Social Security #_____ Relation _____

Phone _____ Group # _____ Ins. ID#_____

Employer Name_____ Ins Effective Date_____

Employer Address_____ Phone _____

AUTHORIZATION:

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I understand and have been informed the uses and disclosures of all my health information to be shared at the discretion of the dentist. (HIPAA compliance)

I understand that I am financially responsible for all fees and charges incurred at Somerset Dental Arts whether or not paid by insurance.

_____ _____

Signature Date

Time 9:30 AM

SOMERSET DENTAL ARTS

Date 7/22/2021

Eaglesoft Medical History (Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ 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 containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

NOTICE OF PRIVACY PRACTICES

Somerset Dental Arts

279 East Main Street
Somerville, NJ 08876

This notice describes how your dental information may be used and disclosed in our office, and how you can get access to this information.

PLEASE REVIEW THIS INFORMATION CAREFULLY

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

USES AND DISCLOSURES OF HEALTH INFORMATION

Our office may use and disclose your dental records only for the following purposes; treatment, payment and health care operations (TPO). TPO activities would include managing and coordinating your dental treatment plan with one or more healthcare providers, obtaining reimbursement for services, gathering insurance information, billing or collections activities and utilization review. It would also include the business aspects of running our practice, such as calling patients at home and/or at work (including leaving voice messages) in reference to any aspect of the practice of carrying out the TPO, sending appointment reminders by mail, filing insurance claims, coordinating laboratory work, and providing information to our patients about health-related benefits and services that may be of interest to you.

Any other uses and disclosures of your *protected health information (PHI)* will be made only with your written authorization. You may revoke this authorization in writing at any time, which our office will honor unless actions were already taken based on your previous consent.

PATIENT RIGHTS

You have the following rights with respect to your protected health information (PHI) which you can exercise by presenting a written request to our office. This includes access to review or obtain copies of your PHI, with limited expectations. A reasonable cost-based fee for expenses such as copies and staff time will accompany all requests for copies. You may request the PHI be in a form other than photocopy, which will be honored unless we cannot practically do so.

You have the right to request that additional restrictions be placed on the use and disclosure of your PHI. We are not required to agree to these additional restrictions but if we do,we will abide by our agreement (except in an emergency).

You have the right to request that we communicate with you about your PHI by alternative means or locations. Your request must be very specific, detailed and must provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

You have the right to receive an accounting of disclosures of your PHI, not to date prior to the effective date of the new HIPAA Privacy Practices in our office

You have the right to request that we amend your health information. Again your request must be in writing, and we hold the right to deny your request under certain circumstances

You have the right to obtain a paper copy of this notice from us upon request.

QUESTIONS AND COMPLAINTS

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 these changes and you may request a written copy of our revised policy from our office.

If you want more information about our privacy practice or have questions or concerns, please notify us.

If you are concerned that we may have violated your privacy rights, or disagree with any decision we made concerning the use and disclosure of your PHI, or as it pertains to your patient rights, you may submit a formal complaint to our office in writing or file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

I HAVE REVIEWED AND UNDERSTAND THE ABOVE STATEMENTS

_____ _____

Signature of Patient or Responsible Party ***Date***

_____

Patient Name (please print)

SOMERSET DENTAL ARTS

Policy on Financial Arrangements

Please read the entire form carefully, then sign and print the date on the back. The following defines the financial policies of our practice.

It is our goal to ensure that each one of our patients receives the highest quality dental care that we can provide. In order to achieve this goal for you, we are happy to offer (if needed) viable options for your financial arrangements with our office.

Payment is due in full at the time treatment is rendered. We accept cash, check, debit cards and all major credit cards. Our office accepts assignments on your dental insurance and will handle processing your claim. If extended time is needed to pay for treatment, ***CareCredit*** provides a monthly financial payout option which allows you to start your dental treatment today.

PAYMENT OPTIONS

FULL PAYMENT:

Payment in full by cash, check, debit card, or credit card is due the day treatment is rendered. The front desk coordinators will **estimate** the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress.

MONTHLY PAYMENTS:

We offer a monthly payment option through ***CareCredit***, a financing company specific to your healthcare needs. You can apply for *CareCredit* right here in our office and receive approval within minutes. This financing option has no annual fee, can be used at other healthcare offices, and has a variety of payment options, some with no interest. **Ask us about *CareCredit* today.**

INSURANCE COVERAGE

We accept many different insurance plans. All plans have a unique schedule of covered services, depending on the plan you or your employer have purchased. There is no guarantee that the services will be covered. You, or the person responsible for this account, will be responsible for payment of non-covered procedures. If you wish, we can send a pre-determination to your insurance carrier. Although you will have the advantage of knowing approximately what your insurance will cover, please be advised this process will delay the necessary treatment.

CANCELLATION POLICY

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. We require and appreciate 24 hours of notice prior to your scheduled appointment when canceling. In the event that you do not show up for your appointment or do not give notice within the above time frame, your account may be charged up to, but not exceeding, $75.00. Leaving a coherent message on the answering machine is acceptable for canceling an appointment and will not be subject to the cancellation fees.

FINANCE CHARGES AND RETURNED CHECKS

In the event that your payment method is declined or payment arrangements are broken without prior notification, your account will be charged a service fee of $25.00. There will be a returned check fee of $25.00 for any bounced check. This fee is subject to increase, depending on the bank's charges and will be added to the outstanding balance. Accounts with an outstanding balance for over 60 days will be sent to collections.

I acknowledge and understand the financial policies of *Somerset Dental Arts* and I agree to them.

_____ _____

Signature of Patient or Responsible Party ***Date***

_____

Patient Name (please print)