Welcome to Ocean Dental Associates!

PATIENT INFORMATION

Last Name: First: Middle:

Cell Phone: ( ) Email:

Address:
Mailing Address

DOB: / / Gender: Marital Status:

Occupation: Patient's Employer/School:

Employer/School #: ( ) Employer/School Address:

Emergency Contact: Relationship: Phone: ( )

DENTAL HISTORY

Please place a mark on "yes" or "no to indicate if you have had any of the following:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Bad breath	☐	☐	Lip or cheek biting	☐	☐	Sensitivity when biting
☐	☐	Bleeding gums	☐	☐	Mouth breathing	☐	☐	Sores or growths in mouth
☐	☐	Blisters on lip/mouth	☐	☐	Mouth pain, brushing	☐	☐	Loose teeth or broken fillings
☐	☐	Dry mouth	☐	☐	Orthodontic treatment	☐	☐	Food collection between teeth
☐	☐	Fingernail biting	☐	☐	Pain around ear	☐	☐	Clicking or popping jaw
☐	☐	Foreign objects	☐	☐	Periodontal treatment	☐	☐	Cigarette/Pipe/Cigar smoking
☐	☐	Grinding teeth	☐	☐	Sensitivity to sweets	☐	☐	Chew on one side of mouth
☐	☐	Gums swollen/tender	☐	☐	Sensitivity to heat	☐	☐	Burning sensation on tongue
☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to cold	☐	☐	Other: ___________________

Reason for Today's Visit:

Former Dentist: City/State:

Date of Last Dental Visit: / / Date of Last Dental X-Rays: / /

DENTAL INSURANCE

Insurance Subscriber: Relationship to Patient:

Insurance Company: Subscriber DOB: / /

PRE-MEDICATION

Do you take antibiotics prior to your dental treatment? *Yes* ☐ *No* ☐

Name & dosage: ____

Reason: ____

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MEDICAL INFORMATION

Please check yes or no. If you do not know, leave it blank.

Yes	No		Yes	No		Yes	No	
☐	☐	Artificial Heart Valve	☐	☐	Lupus/Erythematosus	☐	☐	Kidney problems
☐	☐	Heart murmur/MPV	☐	☐	Cancer/Chemotherapy	☐	☐	Joint replacement
☐	☐	High cholesterol	☐	☐	Eating disorder	☐	☐	Diabetes Type _____
☐	☐	Abnormal bleeding	☐	☐	Hepatitis/Liver Disease	☐	☐	Mental disorder
☐	☐	Stomach problems	☐	☐	Seizure	☐	☐	Congestive Heart Failure
☐	☐	Stroke	☐	☐	Sleep apnea	☐	☐	AIDS/HIV
☐	☐	Heart Attack	☐	☐	Snoring	☐	☐	Rheumatic fever
☐	☐	Angina	☐	☐	Low blood pressure	☐	☐	(Rheumatoid) arthritis
☐	☐	Damaged heart valve	☐	☐	High blood pressure	☐	☐	Emphysema
☐	☐	Heart surgery	☐	☐	Asthma/Bronchitis	☐	☐	Excessive urination
☐	☐	Pacemaker	☐	☐	Radiation	☐	☐	Gastrointestinal issues
☐	☐	Anemia/Hemophilia	☐	☐	Ulcer	☐	☐	Thyroid problem
☐	☐	Osteoporosis	☐	☐	Headaches/Migraines	☐	☐	Night sweats
☐	☐	Endocarditis	☐	☐	Glaucoma	☐	☐	Recurrent infections
☐	☐	Autoimmune disease	☐	☐	Recent weight gain/loss	☐	☐	Neurological disorder
☐	☐	Tuberculosis	☐	☐	Smoking/Chewing tobacco	☐	☐	Congenital heart defect
☐	☐	Epilepsy	☐	☐	Heart disease	☐	☐	Other: _______________

Are you currently on blood thinners? *Yes* ☐ *No* ☐

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®), for osteoporosis or Paget's disease? *Yes* ☐ *No* ☐

Since 2001, were you treated or are you presently scheduled to being treatment with the intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?

Yes ☐ *No* ☐ *Treatment began:* / /

Please explain "yes" answers: ____

____

Do you have any diseases, conditions, or problems not listed above that you think your dentist should know about?

____

____

For Women

Are you pregnant? *Yes* ☐ *No* ☐ Due Date: ______________________ *Are you nursing?* *Yes* ☐ *No* ☐

Taking birth control pills? *Yes* ☐ *No* ☐

MEDICATIONS

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

____

____

____

____

____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic
☐ Barbiturates ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Iodine ☐ Latex
☐ Others: __________________________

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Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for schedules appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read, mark, & initial the items below and sign at the bottom of the form.

1. **Treatment to be provided**

I understand that during my course of treatment, the following care may be provided:

☐ Examinations Preventive Services ☐ Restorations ☐ Crowns Bridges ☐ Other

Patient's Initials: ___________________

2. **Drugs and Medications**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, causing redness and swelling of the tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient's Initials: ___________________

3. **Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient's Initials: ___________________

4. **I give permission** to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient's Initials: ___________________

____

Signature of Patient ***Print Name*** ***Date***

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Financial & Cancellation Policy

Patient Name: ___________________________________ Date: / /

We are committed to providing you with the best possible care. If you have dental insurance, in order to receive the maximum allowable benefit, we need your assistance and understanding of our payment policy.

If the provider does not have a contractual agreement with your insurance company, payment for service is due at the time services are rendered. We accept cash, checks, and credit cards. We will be happy to help you process your insurance claim for reimbursement.

We will gladly discuss proposed treatments and answer any questions relating to your insurance. Please note the following:

1) Our fees are generally considered to fall within acceptable range by most companies; they are covered up to the maximum allowances determined by each carrier. Thus, our fees are considered to be usual and customary by most companies. This statement does not apply to companies who reimburse on an arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.

2) Not all services are covered benefits of all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3) All copayments are to be made at the time of service.

4) You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of overage and you will held responsible for the fees.

5) Returned checks are subject to a $35 service fee.

Late cancellations and missed appointments can prevent other patients from receiving much needed care.

STANDARD APPOINTMENTS MUST BE CANCELLED BY 2:00 PM THE DAY PRIOR TO YOUR APPOINTMENT! FAILURE TO SO WILL RESULT IN A $50 NO-SHOW FEE.

The no-show/late cancellation fee will be billed to you directly and is not covered by insurance. We understand that emergencies arise. If that is the case, please contact us as soon as possible.

We must emphasize that as health care providers we are dedicated to providing the best treatment for our patients. We will do our best in the filing of insurance claims, however, all charges are your responsibility from the date services are rendered.

By signing below, I acknowledge the above policies and authorize the release of any information necessary to determine liability for payment and to obtain reimbursement or request that payment of authorized benefits to be made on my behalf. I assign the benefits payable, to which I am entitled, Medicare, Private insurance, and any other health plans to Ocean Dental Associates.

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Print Name ***Signature***

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PRIVACY ACKNOWLEDGEMENT

I have received the **Notice of Privacy Practice** and I have been provided an opportunity to review it.

Name: ______________________________ DOB: ________________________

Signature: ______________________________ Date: ________________________

Please list any family members or other individuals below that you allow us to speak to or access your records.

Name: ____________________________ Relationship: ________________________

Name: ____________________________ Relationship: ________________________

Name: ____________________________ Relationship: ________________________

Name: ____________________________ Relationship: ________________________

Any additional information you would like Dr. Bui to know:

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I, the patient of Ocean Dental Associates of Toms River, understand everything I have signed. I understand my rights and understand that my information is private. If I have further questions, I can speak to Dr. Bui or a staff member.

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Signature of Patient ***Print Name*** ***Date***