iSmile DENTAL ARTS

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368 Berlin Cross Keys Rd. Williamstown, NJ 080944

Thank you for choosing iSmile Dental Arts to serve you with all your dental needs.

Today's Date: _____

Patient Information

Patient Name: _____ Birth Date: _____

Preferred Name: _____ ☐ Male ☐ Female Social Security #: _____

Employer: _____ Occupation: _____

☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Email Address: _____

Phone (Home): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Referral Information

Whom may we thank for referring you to our practice? Please check **ALL** that apply

☐ Google ☐ Today's Shopper ☐ Insurance ☐ Yelp ☐ Drive By ☐ Walk-in ☐ Reviews ☐ Other_____

Name of person or office referring you to our practice: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Company: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Insurance Company: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Please complete reverse side

Medical Health History

Date of Last Dental Visit: _____ Reason for this visit: _____

Former Dentist _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Autoimmune Disease
- ☐ Asthma
- ☐ Back Problems
- ☐ Bipolar Disorder
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Cerebral Aneurysms
- ☐ Diabetes Type I / II
- ☐ Dizziness/Fainting
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head/Neck Injuries
- ☐ Headaches/Migraines
- ☐ Heart Attack/Stroke
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Problems
- ☐ Pacemaker/Stents
- ☐ Radiation/Chemo
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures/Epilepsy
- ☐ Sinus Problems
- ☐ STD/HPV
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors/ Growths
- ☐ Ulcers

OTHER:

- ☐ _____
- ☐ _____

Are you **allergic** to any of the following?
Please check those that apply:

- ☐ Local Anesthetics (novocaine)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa Drugs
- ☐ Sedatives
- ☐ Codeine or narcotics
- ☐ Iodine
- ☐ Aspirin
- ☐ Latex

OTHER:

- ☐ _____
- ☐ _____

For Woman Only:
Please check those that apply:

- ☐ Pregnant: Due Date_____
- ☐ Nursing
- ☐ Birth Control

Have you ever taken a bone metabolism (osteoporosis) **bisphosphate medication** such as: Boniva, Fosamax, Zometa, Aredia, Actonel, etc.?

☐ Yes ☐ No

If yes, please list which medication and how long:

Do you smoke, vap or use tobacco? ☐ **Yes** ☐ **No**

Do you use Alcohol? ☐ **Yes** ☐ **No**

Please list any medications/supplements that you are currently taking:

_____

_____

_____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone:_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I hereby authorize payment directly to iSmile Dental Arts for all insurance benefits otherwise payable to me for services rendered. I authorize iSmile Dental Arts to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date: _____

Signature of patient, parent or guardian

iSmile DENTAL ARTS

FINANCIAL POLICY AND OFFICE PROCEDUES

To My Appreciated Patient,

This year marks the beginning of many exciting changes in my office in my effort to improve service and quality of care for you so that you can regain and maintain your health as quickly, efficiently, and inexpensively as possible.

I have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you.

If you cannot keep your appointments and adhere to my treatment recommendations, I will not be able to continue treating you in good conscience.

Therefore, the following policies must be agreed upon:

1. No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. There is a $50.00 fee for all no-show appointments and this fee is not covered by insurance.

2. As a courtesy, we will notify you when you have an appointment coming up either by email, text or phone call. We do require written or verbal confirmation for your appointment to remain on the schedule.

3. Timeliness is required. We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

4. Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves.

5. If you miss an appointment you must make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

6. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well-being – we are. We will provide you with an ESTIMATE of benefits; however, you are financially responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.

Please complete reverse side

7. We run a Zero Balance office. We expect payment in full prior to or at the time treatment is provided. We have several financial options available for all our patients. If for some reason a balance remains on your account longer than 30 days a $10 late fee will be assessed to your account every month. If the balance remains on your account for 90 days, your account may be sent to collections and an additional fee of $25.00 will be added to your ledger balance. Please speak to any of our team members if you have any questions.

8. In order to schedule an appointment, we require 50% of the total patient out-of-pocket expense as a deposit and a signed financial agreement.

9. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.

10. Upsets: It is our company policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you should an upset occur provided you bring it to our attention in an appropriate, cordial manner and at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that my staff will treat you with the same professional demeanor and efficiency, as you would expect from them. Please see our office manager to resolve immediately any upsets you may have with my office or one of my team.

11. Emergencies: It is our goal to eliminate all the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this, we would like to define what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms, we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

I greatly appreciate your cooperation,

Yours in Health, Dr. Kassem

_____ _____

(Patient Signature and Date) **(Guardian/ Responsible Party if Minor Signature and Date)**

_____ _____

(Print Patient Name) **(Print Guardian/ Responsible Party Name)**

Staff Initials _____

[Revised 12/30/19]

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GENERAL CONSENT FOR TREATMENT

Patient Name _____ **Birth Date** _____

I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate (for example: for root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges, dentures, oral and parenteral sedation) to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity.

For routine fillings, dental cleanings, prescription of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post-operative infection, nerve damage, and iatrogenic* injury. In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation or breakage of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact my dentist a soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment or surgery.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications, and I promise to use that right to its fullest extent if for any reason I feel I am not fully informed about my procedure, the risks of the procedures, and my alternatives to the procedure.

* An injury that might arise from our treatment or advice.

_____ _____

(Patient/ Guardian Signature and Date) **(Print Guardian/ Responsible Party Name and Date)**

Staff Initials _____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

_____ Date: _____

Signature of patient, parent or guardian

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ **The patient refused to sign**
- ☐ **Due to an emergency situation, it was not possible to obtain an acknowledgment.**
- ☐ **We weren't able to communicate with the patient.**
- ☐ **Other (Please provide specific details)**

HIPPA Acknowledgment of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

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Patient Request for Treatment, Representations and Consent

Responding to the public health hazard posed by Coronavirus disease 2019 ("COVID-19"), effective 5:00 p.m. on Friday, March 27, 2020, Governor Philip D. Murphy ordered and directed the suspension of all surgeries or invasive procedures performed on adults that can be delayed without undue risk to the current or future health of the patient as determined by the patient's treating physician or dentist.

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises

Accordingly, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not, within the past 14 days, travelled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 10 or more persons, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19.

I consent to the performance of the treatment proposed by my dentist.

Name: _____

Signature: _____

Date: _____

368 Berlin Crosskeys Rd, Williamstown, NJ 08094