NORTHFIELD™
FAMILY AND IMPLANT DENTISTRY

We Would Like to Get to Know You Better!

Name: _____ SSN: _____
Last Name First Name Middle Initial

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Seperated ☐ Divorced

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom May We Thank for Referring You? _____ Their Email: _____

In Case of Emergency, Who Should Be Notified? _____ Phone: _____

Reason for Today's Visit: _____

Former Dentist: _____

Address: _____

Date of Last Dental Care: _____ Date of Last Dental X-rays: _____

Check (☑) if You Have Had Problems With Any of the Following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores/Growths in Mouth

How Often Do You Floss? _____ How Often Do You Brush? _____

Physician's Name: _____ Date of Last Visit: _____

Have You Had Any Serious Illnesses or Operations? ☐ Yes ☐ No If Yes, Describe _____

Have You Ever Had a Blood Transfusion? ☐ Yes ☐ No If Yes, Give Approximate Dates _____

(Women) Are You Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (☑) if You Have Had Problems With Any of the Following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Fheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications Currently Taking

_____

_____

Allergies

_____

_____

I Understand That I Am Financially Responsible for All Charges,

Signature: _____ *Date:* _____

Payment is Due in Full at Time of Treatment Unless Prior Arrangements Have Been Approved.

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HIPAA NOTICE of PRIVACY PRACTICE

Dr. Moshe Yeroshalmi
81 Northfield Avenue, Ste. 203
West Orange, NJ 08052
973.325.2725

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and of other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and relates you to your past, present and future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health insurance information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other uses required by law.

Treatment:

We Will use and disclose your protected health insurance to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care by a third party. For example, we would disclose your protected health information, as necessary, to a home health physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment:

Your protected health insurance information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health care information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your potential health information in order to support business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activites, training of medical students, licensing and conducting, or arranging for other businesses activities. For example, your protected health information may be disclosed to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you'll be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose our protected health information, as necessary, to contact you to remind you of your appointment.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR BEFORE APRIL 14, 2003.

We are required by law to maintain the privacy of, and provide indviduals with this notice of our legal duties and privacy practices with respect to protected health information. If you have objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

NORTHFIELD™
FAMILY AND IMPLANT DENTISTRY

81 Northfield Ave, Ste 203
West Orange, NJ 07052
973.325.2725 / www.81northfielddentistry.com

CONSENT

1. I consent to the diagnostic procedures and treatment recommended by Dr. Moshe Yeroshalmi as necessary need for proper dental care.

2. I also consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, obtain payment from insurance, and for those activities and healthcare operations that are related to the treatment or payment.

3. I consent to the disclosure of my records or my child's records to the following persons who are involved in my or my child's dental treatment or payment.

Name:
Address:
Phone Number:
Relationship:

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me

CONTRACT AMENDMENTS
PATIENT RESPONSIBILITIES

1. I understand that I am ***RESPONSIBLE*** for all fees for service.

2. I understand and agree that I am responsible for **ALL THE CO-PAYS** implemented by my insurance based on the contracted fees between Northfield Family & Implant Dentistry and my insurance company. I also acknowledge and agree to pay for any procedures/treatments that I am not eligible for or not covered by my insurance. All co-pays are subject to verification by the explanation of benefits (EOB) issued by the insurance.

3. I understand and agree that if I fail to provide payments to Northfield Family & Implant Dentistry as agreed, I will be responsible for the entire balance in addition to any costs which may result from collection proceedings and/or court proceedings.

4. I agree to pay the estimated fees for any procedures requested by the office at the time of treatment.

Name: (Please Print) _____

Signature:_____

Date: _____