Toms River Smiles Dental
941 Route 37 W #5
Toms River, NJ 08755
732-244-1163
www.trsmiles.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date: / /

Patient Information

First Name:	Middle Name:	Last Name:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Social Security #: - -

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Saw our Office ❑ Insurance Company

❑ Our Website ❑ Other Website: ❑ Other:

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -

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Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -
Insured's SSN:	Insurance Company's Address:	City:	State: ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -
Insured's SSN:	Insurance Company's Address:	City:	State: ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Toms River Smiles Dental to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Toms River Smiles Dental. I permit a copy of this authorization to be used in place of the original. I give Toms River Smiles Dental, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Dental History

Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Discolored	❑ Sensitive to cold
❑ Decay	❑ Missing teeth	❑ Sensitive to heat
❑ Difficulty chewing	❑ Mouth sores	❑ Sensitive when biting

Gums

❑ Bad breath	❑ Abscessed	❑ Sore	❑ Receding
❑ Red (discolored)	❑ Bleeding	❑ Swollen	❑ Periodontal treatment

Miscellaneous

Has the cost of dental treatment been a concern for you? ❍ Yes ❍ No

If yes, how can we help?

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

Medical History

How is your general health? ❍ Good ❍ Fair ❍ Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Phone: - -	Last Visit: /

Address:	City:	State:	ZIP Code:

Do we have permission to contact your doctor regarding your care? ❍ Yes ❍ No

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Have you ever had:

Check all that apply.

- ❑ Arthritis
- ❑ Cancer
- ❑ Heart murmur/trouble
- ❑ History of substance abuse/drug addiction
- ❑ Allergies
- ❑ Diabetes
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Shortness of breath
- ❑ Anemia
- ❑ Epilepsy
- ❑ Hypotension (low blood pressure)
- ❑ Heart attack/stroke
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Mitral valve prolapse
- ❑ HIV/AIDS
- ❑ Cancer/chemotherapy
- ❑ Tuberculosis
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Ulcers/colitis
- ❑ Hospitalized for any reason
- ❑ Thyroid disease
- ❑ Angina
- ❑ Chest pain
- ❑ Herpes
- ❑ Heart disease
- ❑ Hives/skin rash
- ❑ Parathyroid disease
- ❑ Sexually transmitted disease
- ❑ Sinus trouble
- ❑ Cough-persistent or bloody
- ❑ Smoker
- ❑ Swelling of feet/ankles
- ❑ Tumor or growth on head/neck

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex rubber
- ❑ Metals
- ❑ Nitrous oxide
- ❑ Novocaine
- ❑ Penicillin/antibiotics
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Valium
- ❑ Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No
Do you take or have you taken Phen-Fen or Redux? ❍Yes ❍No
Do you smoke or chew tobacco? ❍Yes ❍No
Do you use alcohol, cocaine, or other drugs? ❍Yes ❍No
Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:
All of the above information is correct to the best of my knowledge. 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. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use: Reviewed by:	Title:	Date: / /

T.R. SMILES DENTAL

Patient HIPAA Awareness

With my permission, TR Smiles Dental may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to TR Smiles Dental Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. TR Smiles Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission the office of TR Smiles Dental may call my home or other designated locations and leave message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of TR Smiles Dental may mail to my house or other designated locations and items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. This also includes texting appointment reminders.

With my permission, the offices of TR Smiles Dental may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that TR Smiles Dental restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing TR Smiles dental to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or legal Guardian

_____

Print Name of Patient or Legal Guardian

_____

Date

T.R. SMILES DENTAL

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

☒ For inquiries: Privacy Officer: 900 Tower Drive, Suite 575, Troy, MI 48098, 248-729-0926

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, 'aw enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. r
- We will make sure the person has this authority and can act fo you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/.

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how w share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety,

in these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sell of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury' asks another doctor about your overall health condition.

Run our organization

' We can use and share your health information to run our practice, improve your care, and contact you when necessary.

- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/ privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human

Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information, • We must follow the duties and privacy practices described in this notice and give you a copy of it.
- Other federal and state laws may require special privacy protections that limit the use and disclosure of certain health information about you. For example, such laws may include restrictions on the use and disclosure of genetic information, alcohol, and drug abuse information, HIV/AIDS, mental health, and sexually transmitted diseases. It is our intention to adhere to the more stringent legal requirement when this type of information is used or disclosed.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: June 1, 2017

Signature_____ Date _____

My Medications

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

Medication: _____ Purpose: _____

Dosage: _____ Frequency: _____

T.R. SMILES DENTAL

To My Valued Patient,

This year marks the beginning of many exciting changes in our office in an 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. We have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. We also have a personal, professional, and ethical responsibility to care for your health to the best of our ability. Missed appointments, failure to comply with recommended treatment schedules and/or procedures, as well as other important office policies prevent us from achieving my goal of optimum health for you. If you cannot keep your appointments, adhere to our treatment recommendations, and comply with these policies which we have set forth below for your benefit, we may not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. **Zero Balance office:** Our office operates on a financial policy of each patient having and maintaining no personal monies owed to us. Therefore, all of our patients must have a personal cash balance of zero at the time of treatment. In this office, we do not bill patients, we only bill insurance companies should you have dental coverage in which case we will accept assignment of benefits for this portion of your bill. This means that you will never receive a bill in the mail from our office since all payments not covered by insurance are handled directly with you in the office either at the time or in advance of service. We have several financial options for payment available to all of our patients including our own In-House Insurance Plan. Please speak to our administrative staff if you have any questions.
*Initials*_____

2. **No shows and late cancellations:** These are not acceptable. Failure to make an appointment or cancelling an appointment at the last minute not only compromises your health, but also inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep your scheduled appointment except in the case of an emergency, you are expected to call within 24 hours of your appointment to reschedule the appointment. There is a $75.00 fee for all no-show or late cancellation appointments, and this fee is not covered by insurance.
*Initials*_____

3. **Lateness:** Timeliness is required and expected of all our patients. We will see you on time and get you out on time, unless in the rare occurrence of a delay prior to your appointment due to a legitimate patient emergency which required our immediate attention. If you are more than 15 minutes late for a scheduled appointment, you may be required to reschedule your appointment.

*Initials*_____

4. **Missed Appointments:** If you miss an appointment you must make it up and reschedule it within 24 hours whenever possible. It is critical to your health to do so to avoid any setbacks in the care and maintenance of your teeth and gums.
*Initials*_____

5. **Referring Others to Our Practice:** 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. Please speak to our administrative staff about our referral program.

*Initials*_____

6. **Insurance Coverage:** 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. Please be advised that insurance companies are not concerned about your health or well-being, but we are. We will provide you with an accurate estimate of benefits based upon our years of experience and interactions with your insurance carrier and based on your particular plan whenever possible. However, ultimately you are the one fully 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. It is also your responsibility to immediately inform us of any changes or loss of insurance coverage to assist us in helping you in any way possible, while at the same time ensuring that there no problems or conflicts which may occur as a result.
*Initials*_____

7. **Upsets**: It is our mission 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 at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that our staff will treat you with the same professional demeanor and efficiency as you would expect from them. Please see our Office Manager Doreen to resolve immediately any upsets you may have with any team member.
*Initials*_____

8. **Emergencies:** It is our goal to eliminate all of 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, you have our assurances that we will take care of you in a timely manner. In order to do this, we would like to define for you 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 emergency visits.
*Initials*_____

I greatly appreciate your cooperation, and thank you again for choosing our practice for all of your dental health care needs.

Yours in Health,

Dr. Harihar Kumar DDS

_____ _____
Patient Signature Date