WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐
Bleeding Gums ☐
Blisters on Lips or Mouth ☐
Finger Nail Biting ☐
Grinding Teeth ☐
Lip or Cheek Biting ☐
Loose Teeth or Broken Fillings ☐
Orthodontic Treatment ☐
Pain Around Ear ☐
Periodontal Treatment ☐
Sensitivity to Cold ☐
Sensitivity to Heat ☐
Sensitivity to Sweets ☐
Sensitivity When Biting ☐
Frequent Headaches ☐
Jaw, Head or Neck Injuries ☐
Jaw Difficulty: Clicking and/or Pain ☐
Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐
Anemia ☐
Arthritis, Rheumatism ☐
Artificial Heart Valves ☐
Artificial Joints ☐
Asthma ☐
Back Problems ☐
Bleeding abnormally, with extractions or surgery ☐
Blood Disease ☐
Cancer ☐
Chemical Dependency ☐
Chemotherapy ☐
Chronic Fatigue Syndrome ☐
Circulatory Problems ☐
Congenital Heart Lesions ☐
Cortisone Treatments ☐
Cough - persistent or bloody ☐
Diabetes ☐
Emphysema ☐
Epilepsy ☐
Fainting or Dizziness ☐
Glaucoma ☐
Headaches ☐
Heart Murmur ☐
Heart Problems ☐
Hepatitis-Type _____ ☐
Herpes ☐
High Blood Pressure ☐
HIV Positive ☐
Jaundice ☐
Jaw Pain ☐
Latex Sensitivity ☐
Kidney Disease ☐
Liver Disease ☐
Low Blood Pressure ☐
Mitral Valve Prolapse ☐
Nervous Problems ☐
Pacemaker ☐
Psychiatric Care ☐
Radiation Treatment ☐
Respiratory Disease ☐
Rheumatic Fever ☐
Scarlet Fever ☐
Shortness of Breath ☐
Sinus Trouble ☐
Skin Rash ☐
Stroke ☐
Swelling of Feet/Ankles ☐
Swollen Neck Glands ☐
Thyroid Problems ☐
Tonsillitis ☐
Tuberculosis ☐
Tumor or growth on head/neck ☐
Ulcer ☐
Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Khoa NguyenDMD & Kristen LovelaceDMD, PC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

NGUYEN LOVELACE
Family & Spa Dentistry
1200 Sicklerville Rd - Sicklerville, NJ 08081
(856)885-8162 - KeepYourFamilySmiling.com

OFFICE PHILOSOPHY

Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves on helping you in any way and continuing to provide the quality of care to which you have become accustomed.

ELECTIVE SERVICES

Some services are typically not covered by dental insurance companies. These include, but are not limited to: cosmetic dentistry, implants, occlusion or bite redesign, posterior composites, and other services. Although these are important dental services that can greatly enhance the quality of life for patients, some dental insurance companies do not feel they should have to pay for these services. This is why these services are rarely included in contracts with your employer.

OFFICE POLICIES

We have a state of the art computer system that includes the ability to obtain ESTIMATED dental benefits. **You are expected to pay your estimated portion at the time services are rendered unless other arrangements have been made in ADVANCE.** Please note that our office is a participating provider with several insurance companies, however, we are unable to determine in advance the actual final payment from your dental insurance company. Your ESTIMATED portion may be calculated on the participating insurance fees. We are required to submit our full office fee to your insurance company. You may notice that difference between our in-office billing statement and your explanation of benefits. Please be assured that our office must strictly adhere to the rules, guidelines and fee schedule of any insurance company with whom we have a contract. This includes, but is not limited to, increasing or decreasing the fees charged at the time of service as indicated by the dental insurance explanation of benefits. Upon receipt of final payment from your insurance company, your account may require an adjustment. In the case of overpayment, your account will be credited, and at your request a refund check will be issued. In the event of an underpayment, we will generate a billing statement for the unpaid balance. **It is important to remember, services are provided to you and not to your insurance company. You are financially responsible for all services provided.**

PAYMENTS

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 of our patients. Late fees and finance charges will apply to any overdue balances. Balances over 90 days will be turned over to our collection agency and all fees incurred with become the responsibility of the patient. Please speak with our business staff if you have any questions.

_____
Print Name

_____ _____
Patient/Responsible Party Signature Date

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CANCELLATIONS

Appointments are confirmed a minimum of 2 days in advance. We offer confirmations by phone, text and email. It is greatly appreciated when you have an appointment reserved for you that you call the office to confirm your appointment if we are unable to reach you. **No shows are unacceptable.** Failure to not make your scheduled appointment not only compromises your health, but inconveniences our office as well as other patients who may have wanted the appointment time that was reserved for you. If you cannot make an appointment (except in the case of an emergency), you are expected to call within 2 business days of your appointment to reschedule. All cancelled appointments, late arrivals and no shows are documented by our office and added to your file. **There is a $50 fee for all no-show appointments and appointments cancelled without adequate notice. Habitual disregard of this policy may result in a patient/family dismissal from our office which would be very upsetting for us.**

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, 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 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.

GUARANTEE OF SERVICES

We take great pride in the dentistry we perform here. Our dentistry is guaranteed; under the condition that our patients make a firm commitment to maintain their dental health with office Re-care visits at 3, 4 or 6 month intervals based upon the recommendation of their doctor and hygienist. This is essential to track the progression of your dental health. If you miss an appointment, you must make it up in a reasonable amount of time. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

_____
Print Name

_____ _____
Patient/Responsible Party Signature Date

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please print name of Patient Please sign for Patient/Guardian of Patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, SPECIAL SERVICES, EVENTS, & BILLING INFORMATION VIA:

____ Cell Phone Confirmation ____ Text Message to my Cell Phone ____ Home Phone Confirmation
____ Email Confirmation ____ Work Phone Confirmation ____ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH IS CONVEYED VIA:

____ Cell Phone Confirmation ____ Text Message to my Cell Phone ____ Home Phone Confirmation
____ Email Confirmation ____ Work Phone Confirmation ____ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____ I could not communicate with the patient _____
The patient refused to sign _____ The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer