CAPITAL DENTAL GROUP
Implants, family and cosmetic

Patient Information

401 S. Van Brunt St. Ste 404, Englewood, NJ 07631
Tel: 201.567.5667 Fax: 201.567.5646
www.capitaldentalenglewood.com

Welcome to Capital Dental Group! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient Name:_____ Birth Date:_____ Sex:_____ Age:_____ Marital Status:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Billing Address (If different):_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Email:_____ Driver's Lic. #:_____ State:_____

Soc. Sec. #:_____ Employer/Occupation:_____ Bus. Phone:_____

Spouse's Name & Phone #:_____ Emergency Phone # (Other than spouse):_____

Whom may we thank for referring you?:_____

Insurance Information

Primary Insurance Company:_____ Group #:_____ Date of Birth:_____

Policy Holder's Name:_____ Relationship to Patient:_____ SS #:_____

Name of Employer:_____ Employer Address:_____

Secondary Insurance Company:_____ Group #:_____ Date of Birth:_____

Policy Holder's Name:_____ Relationship to Patient:_____ SS #:_____

Name of Employer:_____ Employer Address:_____

DENTAL HEALTH HISTORY

	YES	NO		YES	NO
Are you apprehensive about dental treatment? _____	☐	☐	How often do you brush? 1 / 2 / 3 or more a day (write one)_____		
Have you had problems with previous dental treatment?_____	☐	☐	How often do you floss? 1 / 2 / 3 or more a week (write one)_____		
Do you gag easily?_____	☐	☐	Does your jaw make noise so that it bothers you or others?_____	☐	☐
Do you wear dentures?_____	☐	☐	Do you clench or grind your jaws frequently?_____	☐	☐
Does food catch between your teeth?_____	☐	☐	Do your jaws ever feel tired?_____	☐	☐
Do you have difficulty in chewing food?_____	☐	☐	Does your jaw get stuck so that you can't open freely?_____	☐	☐
Do you chew on only one side of your mouth?_____	☐	☐	Does it hurt when you chew or open wide to take a bite?_____	☐	☐
Do you avoid brushing any part of your mouth			Do you have earaches or pain in front of your ears?_____	☐	☐
because of pain?_____	☐	☐	Do you have any jaw symptoms or headaches upon		
Do your gums bleed easily?_____	☐	☐	waking up in the morning?_____	☐	☐
Do your gums bleed when you floss?_____	☐	☐	Does jaw pain or discomfort affect your appetite, sleep,		
Do your gums feel swollen or tender?_____	☐	☐	daily routine, or other activities?_____	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?_	☐	☐	Do you find jaw pain or discomfort extremely		
Are your teeth sensitive?_____	☐	☐	frustrating or depressing?_____	☐	☐
Do you feel twinges of pain when your teeth come in contact with:			Do you take medications or pills for pain or discomfort		
Hot foods or liquids?_____	☐	☐	(pain relievers, muscle relaxants, antidepressants)?_____	☐	☐
Cold foods or liquids?_____	☐	☐	Do you have a temporomandibular (jaw) disorder (TMD)?_____	☐	☐
Sours?_____	☐	☐	Do you have pain in the face, cheeks, jaw, joints,		
Sweets?_____	☐	☐	throat, or temples?_____	☐	☐
Do you take fluoride supplements?_____	☐	☐	Are you unable to open your mouth as far as you want?_____	☐	☐
Are you unhappy with the appearance of your teeth/smile?____	☐	☐	Are you aware of an uncomfortable bite?_____	☐	☐
Do you prefer to save your teeth?_____	☐	☐	Have you had a blow to the jaw?_____	☐	☐
Do you want complete dental care?_____	☐	☐	Are you a habitual gum chewer or pipe smoker?_____	☐	☐

MEDICAL HEALTH HISTORY

Do you have, or have you had, any of the following?

	YES	NO
1. Heart problems? If you answered "NO" here, skip to question 2.	☐	☐
Chest pain?	☐	☐
Shortness of breath?	☐	☐
Blood pressure problem?	☐	☐
Heart murmur?	☐	☐
Heart valve problem?	☐	☐
Taking heart medication?	☐	☐
Rheumatic fever?	☐	☐
Pace maker?	☐	☐
Artificial heart valve?	☐	☐
2. Blood problems? If you answered "NO" here, skip to question 3.	☐	☐
Easy bruising?	☐	☐
Frequent nosebleeds?	☐	☐
Abnormal bleeding?	☐	☐
Blood disease (Anemia)?	☐	☐
Ever require a blood transfusion?	☐	☐
3. Allergy problems? If you answered "NO" here, skip to question 4.	☐	☐
Hay fever?	☐	☐
Sinus problems?	☐	☐
Skin rashes?	☐	☐
Taking allergy medication?	☐	☐
Asthma?	☐	☐
4. Intestinal problems? If you answered "NO" here, skip to question 5.	☐	☐
Ulcers?	☐	☐
Weight gain or loss?	☐	☐
Special diet?	☐	☐
Constipation/Diarrhea?	☐	☐
Kidney or bladder problems?	☐	☐
5. Bone or joint problems? If you answered "NO" here, skip to question 6.	☐	☐
Arthritis or Osteoporosis?	☐	☐
Back or neck pain?	☐	☐
Joint replacement?	☐	☐
(e.g., total hip, pins, or implants)		
6. Fainting spells, seizures, or epilepsy?	☐	☐
7. Stroke(s)?	☐	☐
8. Frequent or severe headaches?	☐	☐
9. Thyroid problems?	☐	☐
10. Persistent cough or swollen glands?	☐	☐
11. Premedication required by physician?	☐	☐
12. Cancer/tumor?	☐	☐

Women	YES	NO
13. Are you taking contraceptives or other hormones?	☐	☐
14. Are you pregnant?	☐	☐
If so, expected delivery date:		
15. Are you nursing?	☐	☐
16. Have you reached menopause?	☐	☐
If so, do you have any symptoms?		

	YES	NO
17. Diabetes? If you answered "NO" here, skip to question 18.	☐	☐
Urinate more than 6 times a day?	☐	☐
Thirsty or mouth is dry much of the time?	☐	☐
Family history of diabetes?	☐	☐
18. Tuberculosis or other respiratory disease?	☐	☐
19. Do you drink alcohol?	☐	☐
If so, how much?		
20. Do you smoke?	☐	☐
If so, how much?		
21. Hepatitis, jaundice or liver trouble?	☐	☐
22. Herpes or other STD?	☐	☐
23. HIV-positive/AIDS?	☐	☐
24. Glaucoma?	☐	☐
25. Do you wear contact lenses?	☐	☐
26. History of head injury?	☐	☐
27. Epilepsy or other neurological disease?	☐	☐
28. History of alcohol or drug abuse?	☐	☐
29. Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐
If so, please describe:		

During the past 12 months, have you taken any of the following?

	YES	NO
Anticoagulants (e.g. Coumadin)?	☐	☐
Insulin, Orinase, or similar drug?	☐	☐
Medication for Osteoporosis?	☐	☐
Aspirin?	☐	☐
Nonprescription drug/supplements?	☐	☐

PLEASE LIST ALL MEDICATIONS & THE DOSAGE YOU HAVE TAKEN IN THE PAST 3 MONTHS:

Are you allergic, or have you reacted adversely, to any of the following?

	YES	NO
Local anesthetics ("Novocaine)?	☐	☐
Penicillin or other antibiotics?	☐	☐
Sulfa drugs?	☐	☐
Barbiturates, sedatives, or sleeping pills?	☐	☐
Aspirin, Acetaminophen, or Ibuprofen?	☐	☐
Codeine, Demerol, or other narcotics?	☐	☐
Reaction to metals?	☐	☐
Latex or rubber dam?	☐	☐
Other:	☐	☐

Name of your Physician:

Physician's phone #:

Date of last visit:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

Patient/Parent Signature: **Date:**

Financial Policy & Agreement

Capital Dental Group

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment obligation. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the treatment provider.

Regarding Payment

We accept the following forms of payment: Cash, Check, and all major Credit Cards. Third party no interest financing is available through CareCredit upon request and approval as an option for select terms.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist. We may at times require that Credit Card information be stored on file for special cases requiring large laboratory/material commitments and/or monthly payment arrangements.

If dentures, partial dentures, crowns and bridges are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted. Only in special circumstances, payment arrangements can be broken up at most to the number of visits it takes to fabricate and deliver the prosthesis.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.* In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 45 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
(*If we are a participating provider for your particular insurance plan, you will be responsible for all co-payments required by your insurance company.)

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party:_____ **Date:**_____

Notice of Privacy Practices

Capital Dental Group
401 S. Van Brunt St. Ste 404, Englewood, NJ 07631 Tel:
201.567.5667 Fax: 201.567.5646

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/1/13, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

*You may request a copy of our Notice at any time. For more information about our privacy practices, or for copies of this Notice, please contact us using the information listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer:	Dr. Kimberlie Yun
Telephone:	(201) 567-5667
Fax:	(201) 567-5646
Address:	401 S. Van Brunt St. Ste 404, Englewood, NJ 07631

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):