COVID-19 PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	YES	NO
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Have you recently lost or had a reduction in your sense of smell?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside of the U.S. in the past 14 days? If so, where? _____		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

NAME: _____ DATE: _____

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PATIENT REGISTRATION

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____
Email Address: _____ Date of Birth: ___/___/_____
Sex: ☐ Male ☐ Female Primary Language: ☐ English ☐ Spanish ☐ Other: _____
Emergency Contact: _____ Emergency Phone #: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Date of Birth: ___/___/_____
Occupation: _____ Employer's Name: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____

Spouse

First Name: _____ Middle Name: _____ Last Name: _____
Street: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Date of Birth: ___/___/_____
Occupation: _____ Employer's Name: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____

Preferred Pharmacy

Name: _____ Phone #: _____
Street: _____ City: _____ State: _____ Zip: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____
Employer Name: _____ Insurance Company: _____
Insurance Phone #: _____ Date of Birth: ___/___/_____
Subscriber ID/Policy Number: _____ Group/Contact Number: _____
Patient Relationship to Subscriber: ☐Self ☐Child ☐Spouse ☐Other
Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____
Employer Name: _____ Insurance Company: _____
Insurance Phone #: _____ Date of Birth: ___/___/_____
Subscriber ID/Policy Number: _____ Group/Contact Number: _____
Patient Relationship to Subscriber: ☐Self ☐Child ☐Spouse ☐Other
Subscriber SSN: _____

Referral

Is another member of your family or relative a patient at our office? ☐ Yes ☐ No
Name: _____ Relationship: _____
You were referred to us by: _____

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DENTAL HISTORY

PATIENT NAME: _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?..... ☐
Sweets?..... ☐
Biting or chewing?..... ☐
Have you noticed any mouth odors or bad tastes?. ☐
Do you frequently get cold sores, blisters or any other oral lesions?..... ☐

Do your gums bleed or hurt?..... ☐
Have your parents experienced gum disease or tooth loss?..... ☐
Have you noticed any loose teeth or change in your bite?..... ☐
Does food tend to become caught in between your teeth?..... ☐
If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?. ☐
Bite your lips or cheeks regularly?..... ☐
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)..... ☐
Mouth breathe while awake or asleep?..... ☐
Have tired jaws, especially in the morning?..... ☐
Snore or have any other sleeping disorders?..... ☐
Smoke/chew tobacco or use other tobacco products?..... ☐

Have you ever had:

Orthopedic treatment?..... ☐
Oral surgery?..... ☐
Periodontal treatment?..... ☐
Your teeth ground or the bite adjusted?..... ☐
A bite plate or mouth guard?..... ☐
A serious injury to the mouth or head?..... ☐
If so, please describe, including cause: _____
_____

Have you experienced:

Clicking or popping of the jaw?..... ☐
Pain? (joint, ear, side of face)..... ☐
Difficulty in opening or closing the mouth?..... ☐
Headaches, neckaches or shoulder aches?..... ☐
Sore muscles? (neck, shoulders)..... ☐

Are you satisfied with your teeth's appearance?.. ☐
Do you feel nervous about having dental treatment? ..... ☐
If so, what is your biggest concern? _____
_____
Have you ever had an upsetting dental experience? ..... ☐
If yes, please describe: _____
_____
_____

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe: _____
_____
_____

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MEDICAL HISTORY

PATIENT NAME: _____

1. Have you been under the care of a medical doctor during the past two years?.....Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Are you taking any medication or drugs currently, including over-the-counter herbal medicines?.....
   .....Yes No
   If yes, please list name and dosage: _____
   _____
3. Please check box if you are on or have ever taken:
   - Aspirin/Blood Thinner ☐
   - Actonel ☐
   - Boniva ☐
   - Fosamax ☐
   - Bisphosphonates ☐
   - Other ☐
   - If Other, please specify: _____
4. Are you aware of having an allergic (or adverse) reaction to any medication or substance?....Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years?.....Yes No
   If yes, please explain: _____
6. Indicate which of the following you have had or have at present by checking the box.

Heart (Surgery, Disease, Attack) ☐	Sinus Trouble ☐
Cheat Pain ☐	Radiation Therapy ☐
Heart Murmur ☐	Chemotherapy ☐
High Blood Pressure ☐	Cancer ☐
Low Blood Pressure ☐	Hepatitis A B C (circle) ☐
Mitral Valve Prolapse ☐	Venereal Disease ☐
Artificial Heart Valve ☐	H.I.V. Positive/A.I.D.S. ☐
Heart Pacemaker ☐	Cold Sores/Fever Blisters ☐
Congenital Heart Disease ☐	Blood Transfusion ☐
Atrial Fibrillation ☐	Blood Disorders
Rheumatic Fever ☐	Hemophilia ☐
Arthritis/Rheumatism ☐	Sickle Cell Disease ☐
Stroke ☐	Other ☐
Artificial Joints (hip, knee, etc.) ☐	_____
Kidney Trouble ☐	Liver Disease ☐
Dialysis ☐	Yellow Jaundice ☐
Ulcers ☐	Neurological Disease ☐
Diabetes ☐	Fibromyalgia ☐
Thyroid Problems ☐	Hearing Problems/Hearing Aid ☐
Emphysema ☐	Multiple Sclerosis ☐
Chronic Cough ☐	Muscular Dystrophy ☐
Tuberculosis ☐	Epilepsy/Seizures ☐
Asthma ☐	Fainting/Dizzy Spells ☐
Latex Sensitivity ☐	Nervous/Anxious ☐
Allergies or Hives ☐	Psychiatric/Psychological Care ☐
Seasonal Allergies ☐	→

7. Do you have or have had any disease, condition, or problem not listed?.....Yes No
   If yes, please list: _____
8. **Women:** Are you pregnant or think you may be pregnant?.....Yes, _____ Months No
   Nursing?.....Yes No
9. **Women:** Do you use birth control medication?.....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature_____ Date _____

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DENTAL GROUP

CONSENT FOR TREATMENT

PATIENT NAME: _____

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication 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.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

→

DeMartino Dental Group, P. C.
256 Roseberry Street, Phillipsburg, NJ 08865

ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY

I hereby assign and authorize payment directly to DeMartino Dental Group, P.C. I also understand that **I am responsible to pay my estimated portion at the time of my visit.** If I have secondary insurance, the office will submit my claims but I am responsible to pay the secondary insurance portion at the time of my visit and the secondary insurance payment will be mailed to me. If I fail to make payments, and my account becomes delinquent or is turned over to a collection agency or an attorney for collection, I shall pay all collection costs (33% of the principal balance), court and attorney fees.

I agree, in order for this office to service my account or to collect any amounts I may owe, I may be contacted by telephone at any telephone number associated with my account, including wireless telephone numbers, which could results in charges to me. I may also be contacted by receiving text messages and emails. Methods of contact may include using pre-recorded/artificial voice messages and / or use of an automatic dialing device, as applicable.

*As a courtesy, our office will submit the claims to your insurance company. However it is ultimately your responsibility to know the details and the scope of your insurance coverage / benefits.

Patient's Signature: _____

Date: _____

Parent / Responsible Party's Signature: _____

Relationship to Patient: _____

DeMartino Dental Group, P.C.

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.

_____

(Please print name)

_____

(Signature)

_____

(Date)

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

_____

_____

DeMartino Dental Group, P.C.

Gaeton J. DeMartino, D.M.D.
Jeffrey R. DeMartino, D.M.D., D.A.B.F.D.
Nélida Garcia-DeMartino, D.M.D.

MISSED APPOINTMENT POLICY

We respect the importance of your time and work very hard to schedule appointments which Accommodate the busy scheduling need of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice.

If emergency circumstances prevent you from keeping an appointment we certainly understand, all we ask is that you call us immediately so we can try to accommodate another patient.

Ultimately as with any appointment, it is your responsibility to keep track of your appointments.
We ask you to provide us with a minimum of 48 business hours notification.
Failure to do so may result in a cancellation/missed appointment fee of $90.00 for any appointments that were scheduled with Dr. DeMartino or Dr. Garcia and $45.00 for appointments that were scheduled for hygiene.

We provide as a courtesy, two weeks prior, a reminder call/text message or email for all scheduled appointments. You will also receive an appointment reminder 5 days prior, to confirm your appointment. You will also receive this reminder 2 hours prior to your scheduled appointment. This effort shows our commitment to all of our patients and the importance of their health.

If you have any questions, please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation in this matter.

I confirm that I have read and fully understand all of the information provided.

By signing below, I acknowledge that I have read this statement and agree to the contents.

Signature of patient, parent, or guardian (responsible party):

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Relationship to the Patient: _____ Date: _____

DeMartino Dental Group, PC
256 Roseberry Street
Phillipsburg, NJ 08865
(908) 859-5260

ORAL CANCER SCREENING (VELSCOPE) AUTHORIZATION FORM

Each year in the US alone, approximately 34,000 individuals are newly diagnosed with oral cancer. The death rate from oral cancer is very high; about half of those diagnosed will not survive more than five years. As with all cancer, early detection is the key to its successful treatment.

It is for these reasons that our practice is now utilizing the latest technology to detect oral cancer in its earliest stages. Today, in 3 to 5 minutes you can receive a comprehensive oral cancer examination using this special equipment. The VELSCOPE is an imaging system that uses light to detect oral cancer at its earliest stages.
If an area of concern is located, the doctor may suggest using a small brush to collect cells from that area for a lab examination.

Our office suggests that this VELSCOPE examination be performed annually, unless you have a history of cancer, in which case more frequent VELSCOPE exams are suggested.

The VELSCOPE examination may or may not be covered by your insurance company; therefore, we ask that you tell us if you would like this procedure performed or not and sign this consent form below.

_____ Yes, I would like a complete oral cancer screening using the VELSCOPE at my visit today. I understand that if my insurance does not cover this procedure, I will be responsible for its fee of $23.00.

_____ No, I would not like to get an oral cancer screening using the VELSCOPE. I decline understanding that a visual exam alone is not completely sufficient and may not be accurate in detecting oral cancer in its earliest stages.

Date: _____/_____/_____

Patient's name: _____.

Patient's signature: _____.