Vitarelli Dental

315 Madison Avenue, Madison, NJ 07940 (973) 377-0913

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient's Name: _____ ☐ Male ☐ Female

Preferred Name: _____ ☐ Single ☐ Married ☐ Child ☐ Other
Date of Birth: _____/_____/_____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Mobile Phone: _____ Other: _____

Employer: _____

Address: _____ Work Phone: _____ Ext: _____

City: _____ State: _____ Zip Code: _____

Primary Dental Insurance

Primary Dental Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Group/Plan/Policy #: _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Subscriber's Birth Date: _____ Subscriber's Employer: _____
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Dental Insurance

Secondary Dental Insurance Company: _____

Insurance Address: _____

Insurance Phone: _____ Group/Plan/Policy #: _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Subscriber's Birth Date: _____ Subscriber's Employer: _____
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Medical History

Do you have a personal physician? ☐ YES ☐ NO Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ YES ☐ NO If so please explain: _____

_____

Your current physical health is: ☐ GOOD ☐ FAIR ☐ POOR
Do you smoke or use tobacco in any form: ☐ YES ☐ NO
Have you had any rods, pins, or implants: ☐ YES ☐ NO
Are you taking any prescription/over the counter or herbal supplement drugs? ☐ YES ☐ NO

Please list each one: _____

_____

_____

For Women:

Are you using prescribed method of birth control: ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO Week #: _____
Are you nursing? ☐ YES ☐ NO

Have you ever had any of the following diseases or medical problems:

☐ YES ☐ NO Abnormal Bleeding
☐ YES ☐ NO Alcohol/Drug Abuse
☐ YES ☐ NO Anemia
☐ YES ☐ NO Arthritis
☐ YES ☐ NO Artificial Bones/Joints/Valves
☐ YES ☐ NO Asthma
☐ YES ☐ NO Blood Transfusion
☐ YES ☐ NO Cancer/Chemotherapy
☐ YES ☐ NO Calittis
☐ YES ☐ NO Congenital Heart Defect
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Difficulty Breathing
☐ YES ☐ NO Emphysema
☐ YES ☐ NO Epilepsy
☐ YES ☐ NO Fainting Spells
☐ YES ☐ NO Frequent Headaches
☐ YES ☐ NO Glaucoma
☐ YES ☐ NO Hay Fever
☐ YES ☐ NO Heart Attack
☐ YES ☐ NO Heart Murmur
☐ YES ☐ NO Heart Surgery
☐ YES ☐ NO Herpes/Fever Blisters
☐ YES ☐ NO High Blood Pressure
☐ YES ☐ NO HIV+/AIDS
☐ YES ☐ NO Hospitalized for any reason
☐ YES ☐ NO Kidney Problems
☐ YES ☐ NO Liver Disease
☐ YES ☐ NO Low Blood Pressure
☐ YES ☐ NO Lupus
☐ YES ☐ NO Mitral Valve Prolapse
☐ YES ☐ NO Pacemaker
☐ YES ☐ NO Psychiatric Problems
☐ YES ☐ NO Radiation Treatment
☐ YES ☐ NO Rheumatic/Scarlet Fever
☐ YES ☐ NO Seizures
☐ YES ☐ NO Shingles
☐ YES ☐ NO Sickle Cell Disease/Traits
☐ YES ☐ NO Sinus Problems
☐ YES ☐ NO Stroke
☐ YES ☐ NO Thyroid
☐ YES ☐ NO Tuberculosis (TB)
☐ YES ☐ NO Ulcers

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Are you allergic to any of the following:

☐YES	☐NO	Aspirin	☐YES	☐NO	Erythromycin		☐YES	☐NO Tetracycline
☐YES	☐NO	Codeine	☐YES	☐NO	Latex	OTHER:	_____	
☐YES	☐NO	Dental Anesthetics	☐YES	☐NO	Penicillin		_____	

Dental History

What is the reason for your visit today: _____

Your current dental health is…	☐Good	☐FAIR	☐POOR
Do you like your smile?	☐YES	☐NO	
Do your gums bleed?	☐YES	☐NO	
Are our teeth sensitive to heat, coddle, or anything else?	☐YES	☐NO	
Have you ever had a serious/difficult problem associated with any previous dental works?	☐YES	☐NO	
Do you now or have you ever experienced plant/ discomfort in your jaw joint (TMJ/TMD)?	☐YES	☐NO	

Office Policies

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Payment is due in full at time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

NOTICE TO ALL PATIENTS

We reserve appointment times to properly serve you and our other patients. If you are not able to keep your appointment please contact our office immediately. This advanced notice allows us the opportunity to serve other patients by placing them into the time slot. Thank you.

***AS OF JANUARY 1, 2010, THERE WILL BE A $50.00 CHARGE FOR ALL MISSED/CANCELLED APPOINTMENTS UNLESS WE ARE GIVEN 24 HOURS ADVANCED NOTICE.**

I have read and understand the above statement

_____ _____

Signature Date

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Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fee if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

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☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: _____ Date: _____

Relationship to Patient:

_____ Response Date: _____