REGISTRATION
(PLEASE PRINT)

JOSEPH T. BUZZANCO, D.M.D.
208 Maple Avenue
Red Bank, NJ 07701

Telephone: (732) 747-1122

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

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

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Medical History Form

Patient's Name _____ Date _____

In case of emergency who should be notified? _____ Phone ( ) _____

Sex M F Height _____ Weight _____

If you are completing this form for another person, what is our relationship to that person?

_____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? . . . . . Yes No
2. Has there been any change in your general health within the past year? . . . . . Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? . . . . . Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? . . . . . Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine?. . . . . Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease . . . . . Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . Yes No
      1. Do you have chest pain upon exertion? . . . . . Yes No
      2. Are you ever short of breath after mild exercise or when lying down? . . . . . Yes No
      3. Do your ankles swell? . . . . . Yes No
      4. Do you have inborn heart defects? . . . . . Yes No
      5. Do you have a cardiac pacemaker? . . . . . Yes No
   c. Allergy . . . . . Yes No
   d. Sinus trouble . . . . . Yes No
   e. Asthma or hay fever . . . . . Yes No
   f. Fainting spells or seizures . . . . . Yes No
   g. Persistent diarrhea or recent weight loss . . . . . Yes No
   h. Diabetes . . . . . Yes No
   i. Hepatitis, jaundice or liver disease . . . . . Yes No
   j. AIDS or HIV infection . . . . . Yes No
   k. Thyroid problems . . . . . Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. . . . . Yes No
   m. Arthritis or painful swollen joints . . . . . Yes No
   n. Stomach ulcer or hyperacidity . . . . . Yes No
   o. Kidney trouble . . . . . Yes No
   p. Tuberculosis . . . . . Yes No
   q. Persistent cough or cough that produces blood . . . . . Yes No
   r. Persistent swollen glands in neck . . . . . Yes No
   s. Low blood pressure . . . . . Yes No
   t. Sexually transmitted disease . . . . . Yes No
   u. Epilepsy or other neurological disease . . . . . Yes No
   v. Problems with mental health . . . . . Yes No
   w. Cancer . . . . . Yes No
   x. Problems of the immune system . . . . . Yes No
9. Have you had abnormal bleeding?. . . . . Yes No
   a. Have you ever required a blood transfusion? . . . . . Yes No
10. Do you have any blood disorder such as anemia? . . . . . Yes No
11. Have you ever had any treatment for a tumor or growth? . . . . . Yes No

(over)

12. Are you allergic or have you had a reaction to:

a. Local anesthetics	Yes	No
b. Penicillin or other antibiotics	Yes	No
c. Sulfa drugs	Yes	No
d. Barbiturates, sedatives, or sleeping pills	Yes	No
e. Aspirin	Yes	No
f. Iodine	Yes	No
g. Codeine or other narcotics	Yes	No
h. Other _____		

13. Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, explain _____

14. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
If so, explain _____

15. Are you wearing contact lenses? Yes No

16. Are you wearing removable dental appliances? Yes No

16A. Do you have a Prosthetic Device? Hip, Knee or Joint? Yes No

Women

17. Are you pregnant? Yes No

18. Do you have any problems associated with your menstrual period? Yes No

19. Are you nursing? Yes No

20. Are you taking birth control pills? Yes No

Chief Dental Complaint _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

_____ _____
(Date) Signature of Dentist

Medical history update:

Date	Comments	Signature

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES 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: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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 & 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** BE CONVEYED VIA:

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

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

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.

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* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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 _____

August 1, 2022

Broken Appointment/ Last Minute Cancellation Policy

When a patient is scheduled for an appointment, that time is set aside for you and you only. It is not our policy to double book. We value your time and ask that you value ours. If you need to cancel your appointment you will need to call and **speak directly** to one of our receptionists, giving a minimum of 48-hour notice prior to your appointment time. Messages left on our service after hours are acceptable provided that message is left at least 72 hours prior to your appointment.* This will allow us to fill the appointment with someone on our waiting list. Maintaining your oral health is of utmost importance to us. We will do our best to reschedule your cancelled appointment as soon as possible.

The following fees will be charged if above policy is not followed.

Hygiene appointment----------$75.00

Doctors' appointment--------$100.00

*We understand that sudden illness is unpredictable. This policy will be waived provided a doctor's note is provided.

Patient's/Guardian Signature_____ Date_____

(I have read and accept the above policy. Any questions have been asked and answered.)
The above fees are not covered by insurance and will be the responsibility of the responsible party on the account.