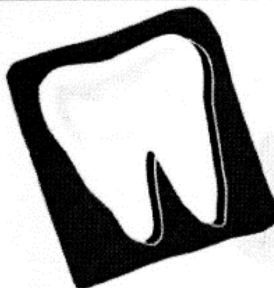
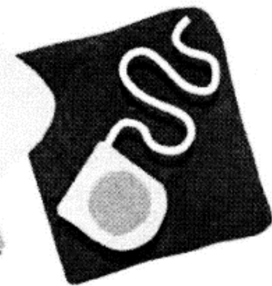
WELCOME
TO OUR PRACTICE!





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 ______________ (Last Name) ______________ (First Name) ______ (Initial) Home Phone ______________

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: ______________________

____

	Yes	No
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:

	Yes	No
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 ______________________ 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 ______________________

Joseph J. Olechowski D.M.D.
12-15 Broadway
Suite C
Fair Lawn, NJ 07410
201-797-2300

Financial Responsibility

I understand that I am financially responsible for all charges, whether or not paid by insurance. I understand that if I do not pay the entire balance, or previously agreed upon amount, within 28 days of the monthly billing date, a finance charge of 18% (1 ½ %) will be assessed each month.

I understand that I will be charged a fee of $25.00 for any month a payment is not made on an existing balance. I realize that failure to keep this agreement will result in interruption of elective dental procedures.

I agree to pay late charges, collection costs and any other reasonable fees necessary to collect on this amount or any future outstanding balances incurred by me or a member of my family for whom I am financially responsible.

Guarantor Signature_______________________________
Relationship to patient_______________________________
Date_______________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Joseph J. Olechowski DMD

12-15 Broadway Suite C

Fair Lawn, NJ 07410

201-797-2300 || Fax 201-797-8626

No-show/Late Cancellation Policy Form

This practice reserves the right to charge a $50 no show/late cancellation fee to patients who fail to keep their appointments, or do not cancel their appointments 24 hours in advance without notifying the practice.

To help patients remember their scheduled appointments, we send out text message reminders 5 days, 2 days, and 3 hours in advance of the appointment time. If not confirmed by text message we also call 1 or 2 days prior to the scheduled appointment day.

As a courtesy to our office as well as to those patients who are waiting to schedule with Dr. Olechowski, please give us at least **24 hour notice**. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50 "no-show/ late cancellation" service charge to your account. This "no-show charge/ late cancelation" is not reimbursable by your insurance company. You will be billed directly for it.

I, (please print)____, have read and understand the No Show/Late Cancelation policy and do agree that if I do not cancel my appointment 24 hours prior to my appointment, or if I do not attend my appointment, I will be charged the $50 fee.

Patient signature: ________________________________ Date:__________________________