DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext. _____ Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping Pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____

_____

Reason for Today's Visit:

_____

_____

5 HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

Please mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Bleeding Abnormally with			Type _____			Skin Rash	❑ Yes	❑ No
Extractions or Surgery	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Swelling of Feet		
Chemical Dependency	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	or Ankles	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Cough, Persistent or			Mitral Valve Prolapse	❑ Yes	❑ No	Tumor or Growth		
Bloody	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	on Head or Neck	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Women: Are you pregnant?	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No	Are you nursing?	❑ Yes	❑ No	Unexplained Weight Loss	❑ Yes	❑ No
			Due Date _____					

6 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	❑ Yes	❑ No	Burning Sensation on Tongue	❑ Yes	❑ No	Loose Teeth or Broken Fillings	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No	Chew on One Side of Mouth	❑ Yes	❑ No	Mouth Breathing	❑ Yes	❑ No
Blisters on lips/mouth	❑ Yes	❑ No	Cigarette, pipe, or Cigar Smoking	❑ Yes	❑ No	Mouth Pain, Brushing	❑ Yes	❑ No
			Clicking or Popping Jaw	❑ Yes	❑ No	Orthodontic Treatment	❑ Yes	❑ No
			Dry Mouth	❑ Yes	❑ No	Pain Around Ear	❑ Yes	❑ No
			Fingernail Biting	❑ Yes	❑ No	Periodontal Treatment	❑ Yes	❑ No
			Food Collection Between the Teeth	❑ Yes	❑ No	Sensitivity to Cold	❑ Yes	❑ No
			Foreign Objects	❑ Yes	❑ No	Sensitivity to Heat	❑ Yes	❑ No
			Grinding Teeth	❑ Yes	❑ No	Sensitivity to Sweets	❑ Yes	❑ No
			Gums Swollen or Tender	❑ Yes	❑ No	Sensitivity when Biting	❑ Yes	❑ No
			Jaw Pain or Tiredness	❑ Yes	❑ No	Sores/Growths in Mouth	❑ Yes	❑ No
			Lip or Cheek Biting	❑ Yes	❑ No	How often do you floss? _____		
						How often do you brush? _____		

7 UPDATES

(To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____

RJ DENTAL
RICHARD E. BUFFONG, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have reviewed 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

RJ DENTAL

RICHARD E. BUFFONG, D.M.D.

NOTICE OF PRIVACY PRACTICES

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 (07/23/09), 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 additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $10.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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.

Contact Officer: Edhybet Figueroa

Telephone: (201) 837-6666; (908) 241-6455 Fax: (201) 836-4611; (908) 241-6367

E-mail: buffongdmd@optonline.net

Address: 175 Cedar Lane, Suite 10 Teaneck, NJ 07666; 121 – 125 Chestnut Street, Suite 201 Roselle, NJ 07203

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

RJ Dental Teaneck

Richard E. Buffong, D.M.D.

OFFICE POLICY

Appointments

We schedule hours of service by appointment only. **This time is reserved especially for you**, Please arrive 5 –10 minutes prior to your appointment. A broken appointment fee of **$75.00** will be posted to your account for any same day, late cancellations or no shows. If you arrive **20 minutes** late for your appointment, your appointment will be rescheduled and the visit will be considered a late cancellations.

Office Hours

Monday &Wednesday 9:00am- 6:00 pm Thursday 9:00am – 7:00pm

Financial

In order to maintain the cost of treatment to a comfortable minimum by not billing out statements,

Patient portions are due at time of services rendered.

We accept American Express, MasterCard, Visa, Discover, Personal Checks and Cash.

I hereby authorize and guarantee payment for all services rendered, although fees for services are due and payment expected at the time services are rendered if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50% court costs, attorney fees and interest fees accrued with the collection of this account.

In House Credit Plan

Our financial arrangements consist of interest free plans from 3–24 months
and extended payment plans with a 16.90% interest.
In House Credit Plan applications processed while you wait.

Insurance

As a **courtesy** to you, we investigate your insurance plan, and offer to accept patient portion in anticipation of receiving forthcoming estimated insurance portions. However, dental insurance estimate is not a guarantee of payment and you will be responsible for any fees your insurance plan **does not** cover.

You are responsible for payment in full at time of service.

I have read, understand and accept the office policy procedure and agree to act accordingly.

_____

Signature of Patient or Guardian ***Date***

RJ Dental Roselle

Richard E. Buffong, D.M.D.

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Appointments

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Office Hours

Monday 10am -5pm Tuesday & Friday 9am-5pm Wednesday 10am-7pm Saturday 8am-1pm

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