renaissance dental care

Renaissance Dental Care LLC
General, Cosmetic & Implant Dentistry
1520 US HWY 130 N, North Suite
102 North Brunswick NJ 08902
Phone: (732) 422 1400
renaissancedentalcare.com

Patient Information Form

Date:

Name:_____
Last Middle First
Address:_____
City:_____State:_____Zip:_____
Telephone:(Home):_____(Work):_____
(Cell):_____Email:_____
_____Sex:_____ Marital Status: Single Married Child Other
Social Security Number:_____Birth Date:_____
Employers Name and Address:_____
Occupation:_____
Referred By:_____
In case of an emergency ,contact:_____Telephone:_____
Dental Insurance Company:_____Telephone:_____
Address:_____Group No:_____
Patient I.D. Number:_____
Are you the Primary Card Holder for this plan? Yes No
If no, please provide Name, SS # and DOB of insured:

_____
Last First SS# Date of Birth
Relationship to the insured:_____
Insured's Employer Name:_____
Address:_____
Secondary Insurance (if any):_____
_____
Date of last Dental examination:_____
Date of last series of complete mouth x-rays:_____

	Yes	No
Are you in good health?		
Any change in general health in the last five years?		
Do your gums bleed?		
Are you happy with your smile?		
Do you smoke?		
Are your teeth yellow?		
Would you like to change your smile?		
Would you like to whiten your teeth?		
Have you been pre-medicated with antibiotics before any dental treatment?		
We encourage six-monthly visits to maintain good dental health Is there a reason you will not be able to keep regular visits?		

List ALL hospitalizations and serious illnesses, including dates:

1. _____
2. _____
3. _____

Diagnosed with a heart murmur / mitral valve

Heart attack, angina or other heart disease?

Irregular heartbeat or pacemaker?

High blood pressure?

Asthma, emphysema or difficulty breathing?

Stroke, seizures or convulsions?

Diabetes?

Recent increase in urination?

Thyroid problems?

Kidney trouble or renal dialysis?

Hepatitis, lever disease, or jaundice?

Tuberculosis?

Psychiatric treatment?

Autoimmune disease or lupus erythematosus?

Blood disorder, bleeding tendency or frequent bruising?

Rheumatic Fever or rheumatic heart disease?

Prosthetic or artificial heart valve?

Shortness of breath after mild exercise?

Swollen ankles?

Recent increase in thirst?

Stomach ulcers or stomach problems?

AIDS, ARC, HIV infection?

Arthritis or rheumatism?

Prosthetic or artificial joint?

Cancer, radiation treatment, or chemotherapy?

Venereal disease? Syphilis? Gonorrhea?

Persistent cough or coughing up blood?

Enlarged lymph nodes or swollen glands?

Hearing problem or vision problems?

Do you have any allergies?

If yes, what?

_____

Have you ever taken penicillin?

Have you ever had a bad reaction to any drug or medication?

If yes – what?

Penicillin or other antibiotic?

Aspirin?

Dental anesthetic

Codeine or other narcotics

Other

[WOMEN ONLY]

Are you pregnant?

List all of the drugs or medications you are taking now:

Name of Medication	**Dosage**	**How Long?**	**Reason**

Are you under the care of a physician?

Please provide the MD's name, address and phone number:

In addition to those you have listed, have you taken any of the following medications or drugs within the <u>past year</u>? If yes, please check the appropriate box.

Medication for asthma	Anticoagulants (blood thinners)	Cortisone / other steroids
Medication for anxiety (nerves)	Medication for stomach ulcers	Medication for high blood pressure
Medication for depression or a disorder	Cancer, Chemotherapy	Insulin or pills for diabetes
Medication for a heart problem	Aspirin, arthritis / pain medication	AZT / other drugs for HIV infection
Nitroglycerin or any medication for angina or chest pain	Methadone maintenance	Other:_____

I understand and authorize Dr. Madhavi Kaluskar, associates and staff to take all diagnostic materials needed to make a final diagnosis for dental treatment. Diagnostic materials may include intraoral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides. This material may be used for articles and / or publications.

I authorize Dr. Madhavi Kaluskar, associates and staff to perform and administer any and all forms of treatment, medication and anesthesia that may be necessary. I understand that the dental treatment presented to me is my financial responsibility and that all fees for services are due and payable upfront and / or at the completion of treatment as authorized by Dr. Madhavi Kaluskar and / or administrator.

I will assume responsibility of notifying Dr. Kaluskar, her associates and staff of any changes in my medical history or contact information.

I understand that Dr. Madhavi Kaluskar, her associates and staff reserve the right to change the terms of their Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request before signing this consent.

I give Dr Madhavi Kaluskar, associates and staff my consent to use or disclose my protected health information in order to carry out treatment, to obtain payment from insurance companies and for healthcare quality reviews .I understand I may revoke this consent by making a written request except for the information already used or disclosed.

Patient's Signature_____ Date:_____

My preferred method of contact is email home phone cell phone

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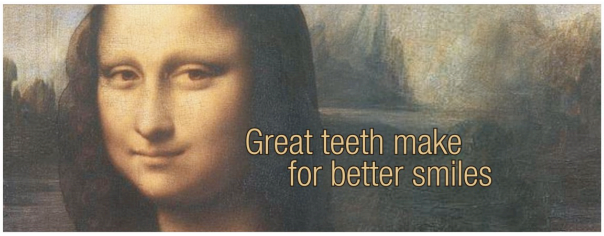

Welcome to our Practice!

We are so pleased that you chose to come to us. We will do our best to ensure that this will be a great relationship. Here are some expectations we will strive to satisfy and some responsibilities we like our patients to assume:

1. **Treatment**:
   - For many dental problems there are several treatment options. We offer a spectrum of services and will always give you a choice and recommendation of options. We will also inform you of the natural consequences of doing no treatment. We encourage you to ask questions if there is something you do not understand.

2. **Appointments**:
   - We will schedule your appointments as quickly and conveniently as possible and send out reminders by email, phone call or text message as you prefer. If you need to reschedule or cancel an appointment, at least 48 hours notice is requested. Failure to give us 24 hours notice will result in a $35 fee. If this happens again, the third visit will require a deposit of $100 that is forfeited on not keeping the appointment.
   - We respect your time and will try not to make you wait. In turn we ask you to be timely for your appointments, so we do not fall behind schedule with other patients.
   - All of us work hard to maintain a 6 month recall system for all patients. It helps us provide you with the best dental care. We schedule these appointments well ahead and remind you as the appointment draws nearer, so you can make changes if you need to. It will be a great benefit to you, if you help us by keeping these appointments regularly. For those of you using dental insurance it will help make the best use of your benefits and keep you in great dental health.

3**. Payment for services**:
   - Patients are responsible for payments for all services rendered at each visit. Certain procedures require full payment before cases are sent to the lab. We do have several convenient payment options.
   - For patients using insurance to help pay for dental treatment, we call the insurance company to understand the particulars of your plan and encourage you to do the same.
   - Most insurance plans encourage regular visits to stay healthy by covering preventive visits at 100%.Other procedures are usually covered to different extents depending on the plan negotiated by your employer. Anything not paid by the insurance company is your responsibility.
   - We will do our best to give you the amount of co-pay due ahead of the visit and urge you to ask any questions you may have about insurance, before your appointment time so we do not spend treatment time explaining co-pays.

I acknowledge that I have and read and understood the above guidelines

Signature_____ Print Name_____