WELCOME TO
Lafayette Family Dentistry
50 Route 15
Lafayette, N.J. 07848
973-579-7888

PATIENT INFORMATION

Name_____ Birthday_____
Address_____ City_____ State_____ Zip_____
Social Security #_____-_____-_____
Home Phone Number_____ Work Phone Number_____
Cell Number_____ **E-mail Address** _____
Employer_____ Position/Occupation_____
Person to Contact in Emergency_____ Phone Number_____

RESPONSIBLE PARTY

Name of Person Responsible for Account_____ Relationship_____
Address_____ City_____ State_____ Zip_____
Home Phone Number_____ Work Phone Number_____
Cell Number_____ Signature_____

FINANCE CHARGE OF 1.5% WILL BE ADDED TO ACCOUNTS OVER 60 DAYS

INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____
Birthday_____ Social Security #_____-_____-_____
Employer_____ Work Phone_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____Union or Local #_____
Address_____ City_____ State_____ Zip_____
How Much is Your Deductible?_____ What is Your Calendar Year Benefit?_____

SECONDARY INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____
Birthday_____ Social Security #_____-_____-_____
Employer_____ Work Phone_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____Union or Local #_____
Address_____ City_____ State_____ Zip_____
How Much is Your Deductible?_____ What is Your Calendar Year Benefit?_____

Whom May We Thank For Referring you?

PATIENTS NAME:_____ **DATE:**_____

MEDICAL HISTORY

Do you have or have you had….

Any type of artificial implant or prosthesis?..... Yes or No
Any change in your health recently?..... Yes or No
A physical within the past year?..... Yes or No
Any serious illness or operations?..... Yes or No

If so please describe_____

Heart Murmur/Mitral Valve Prolapse?..... Yes or No
Rheumatic fever or rheumatic heart disease?..... Yes or No
Congenital heart lesions?..... Yes or No
Pacemaker?..... Yes or No
Cardiovascular disease (heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?..... Yes or No
Artificial Heart Valves?..... Yes or No
Fainting spells or seizures?..... Yes or No
Asthma?..... Yes or No
Hives or skin rash?..... Yes or No
Allergies?..... Yes or No

If so, to what?_____

Allergies to penicillin?..... Yes or No
Allergies to sulfa drugs?..... Yes or No
Allergies to codeine or other narcotics?..... Yes or No
Allergies to local anesthetic?..... Yes or No
Any history of diabetes?..... Yes or No
Any history of arthritis?..... Yes or No
Any history of Kidney trouble?..... Yes or No
Any history of Cancer? Where?..... Yes or No
If so, does treatment regimens include bisphosphonates?..... Yes or No
Are you currently taking or have a history of taking osteoporosis medication?..... Yes or No
Any history of Thyroid problems?..... Yes or No
Any history of tuberculosis?..... Yes or No
Any history of alcohol or substance abuse?..... Yes or No
Any history of venereal disease?..... Yes or No
Any history of Auto-Imune Disease (AIDS)?..... Yes or No
Any type of blood disorder or anemia?..... Yes or No
Are you currently taking any medication?..... Yes or No

If so please list_____

Any history of radiation treatment?..... Yes or No
Do you have any disease, condition, or problem that you think I should know about?..... Yes or No
If so please explain.....
Any clicking of jaw or discomfort?..... Yes or No
Do you smoke?..... Yes or No

WOMEN:

Are you pregnant?..... Yes or No
How many weeks?.....
Do you breast feed?..... Yes or No
Do you take birth control pills?..... Yes or No

Signature:_____ Date:_____

PRIVACY ACT

RELEASE: I grant permission for release of insurance information from Lafayette Family Dentistry to any third party payers and/or agents for the purpose of any concurrent or retrospective review, which may be required for processing any claim for payment. I also grant permission to Lafayette Family Dentistry to release dental information to other treating specialist(s). Copy of our office policies required for **Health Insurance Portability and Accountability Act (HIPPA)** available upon request.

I grant permission for confirmation call to be left on voicemail and or family members

My signature indicates that I have read, understand and agree with the above statements.

PATIENTS NAME: _____ (please print)

PATIENTS SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE (if necessary): _____

RELATIONSHIP TO PATIENT: _____

NOTICE OF PRIVACY PRACTICES

PLEASE SIGN ONE OF THE FOLLOWING

I_____ (please sign name) have received a copy of this office's Notice of Privacy Practices.

I_____ (please sign name) refused a copy of this office's Notice of Privacy Practices.