Casperino & Salvador
Quality Dental Associates
Dr. Pamela Casperino & Dr. Victor Salvador
204 Highway #71 Spring Lake Hts., N.J. 07762
732-974-9741
www.drscasperinoandsalvador.com

## Patient Information

Name _____
First Last

Address _____

City _____ State _____ Zip _____

Home ( ) _____

Cell ( ) _____

E-Mail _____

Social Security # _____

Birthdate _____/_____/_____ Age _____

Sex ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated
☐ Divorced ☐ Minor ☐ Partnered

Spouse's Name _____

Birthdate _____/_____/_____ Age _____

Social Security # _____

Spouse's Employer _____

## Responsible Party (If under age of 18)

Name _____
First Last

Address _____

City _____ Zip _____

Phone # ( ) _____

Birthdate _____/_____/____ Relationship to Patient _____

## Employment

Occupation _____ Employer _____

Business Address _____

Phone # ( ) _____ How Long ? _____

## Emergency Contact

Name _____
First Last

Phone # ( ) _____ Relationship _____

## Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Insured's Soc. Sec. # _____

Insurance Company _____

Member ID _____ Group # _____

Plan Name _____

Address _____

City _____ Zip _____

Insurance Phone # ( ) _____

## Secondary Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Insured's Soc. Sec. # _____

Insurance Company _____

Member ID _____ Group # _____

Plan Name _____

Address _____

City _____ Zip _____

Insurance Phone # ( ) _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to QD 775 Union Blvd, LLC 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 dentist 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

_____
Signature of Patient, Parent, Guardian or Personal Representative

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

_____ _____
Date Relationship to Patient

Reason for today's visit_____

Former Dentist _____

City/State _____

Last dental visit _____

Who may we thank for your referral? _____

# Dental History

**How frequently do you brush your teeth?**

- ☐ 3(+) a day
- ☐ Twice a day
- ☐ Once a day
- ☐ Weekly
- ☐ Never

**How frequently do you floss your teeth?**

- ☐ 1(+) a day
- ☐ 2-6 times weekly
- ☐ 1-6 times monthly
- ☐ Never

**Please mark any of the following to indicate YES in response to the question:**

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Do you feel you have bad breath?
- ☐ Are any of your teeth currently causing you any pain?
- ☐ Are you aware of grinding your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ History of Orthodontic Treatment? Approx. Date _____

**If you could change anything about your mouth, teeth or smile what would it be?**

_____

# Medical History

**Physician's Name** _____ **Date of Last Visit** _____

**City & State** _____ **Phone #** _____

**Pharmacy** _____ **City & State** _____ **Phone #** _____

**Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"?** ☐ **Yes** ☐ **No**
These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)

**Have you had any serious illnesses or operations?** ☐ **Yes** ☐ **No** **If yes, please explain** _____

_____

**Have you ever had a blood transfusion?** ☐ **Yes** ☐ **No** **If yes, give approximate date** _____

**WOMEN →** **Are you pregnant?** ☐**Yes** ☐**No** **Due Date** _____ | **Nursing?** ☐**Yes** ☐**No** | **Taking birth control?** ☐**Yes** ☐**No**

- ☐ Allergies (Seasonal)
- ☐ Autoimmune Disease
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemo/Radiation Therapy
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye Problems

- ☐ Fainting/Dizziness
- ☐ Fosamax Use
- ☐ Headache's
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophillia
- ☐ Hepatitis, Type ___
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure

- ☐ Lung Disease
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis

**Medications & Dosage**

_____
_____
_____
_____
_____
_____
_____
_____
_____

•**Allergies :** ☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin
Other _____

**To the best of my knowledge, I have answered every question completely and accurately.**
**I will inform my dentist of any changes in my health and/or medicine.**

_____ _____

Signature (Parent if Patient is under 18) Date

# Acknowledgment of Office Forms

## Please initial next to each Form received and sign at bottom of this notice.

☐ Quality Dental Associates Notice of Privacy Practices

By Signing below I acknowledge receipt of Quality Dental Associates Notice of Privacy Practices. I hear by give consent to Quality Dental Associates to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

☐ Quality Dental Associates Financial Policy

By Signing below I acknowledge receipt of Quality Dental Associates Financial Policy. I have read the above conditions of treatment and payment and agree to their content.

☐ Quality Dental Associates Internet Communications Form

By Signing below I acknowledge receipt of Quality Dental Associates Internet Communications regarding the secure uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

_____ _____

Signature of patient, parent or guardian Date

_____

Patient Name

_____

Relationship to Patient

Quality Dental Associates
204 Highway #71
Spring Lake Heights, N.J. 07762

# 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 04/14/2003 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 notices effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change the 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 providers 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, accreditations, 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 authorization, you may revoke it in writing at an time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us 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 payments 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 disclosers. 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 institutions 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, letters, emails, text messages, news 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 $0.10 for each page, $15.00 per hour staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate 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 or 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 Communications:** 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 website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

**QUESTIONS AND COMPLAINTS**
If you want more information on 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 alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Service. 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 anyway if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.
**Contact Officer: Office Manger**
**Telephone : Totowa: 973-812-1234 OR Spring Lake Hts. : 732-974-9741**

# Financial Policy

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment, as well as completing our Patient History/Insurance form before seeing the doctor.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
**WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AMEX, MASTERCARD & CARECREDIT.**
**CREDIT TRANSACTIONS ARE SUBJECT TO A 3.99% SURCHARGE, WHICH IS NOT GREATER THAN THE COST OF ACCEPTANCE.**
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

**Regarding Insurance**
We may accept assignment of benefits. However, we do require you pay your estimated co-payments at the time of treatment. We cannot bill your insurance company unless you provide your full insurance information. Your insurance policy is a contract BETWEEN YOU AD YOUR INSURANCE COMPANY. We are not party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under Dental Insurance.

**Usual and Customary Rates**
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Missed Appointments**
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

# Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand the State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that he dental practice has the right to monitor retrieve, store, upload and use my information in connection with the operations of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILTY FOR MY USE OR MISUSE OF APTIENT INFORMATION OR OTHER INFORAMTION TRANSMITTED, MONITOREDM STORES, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.