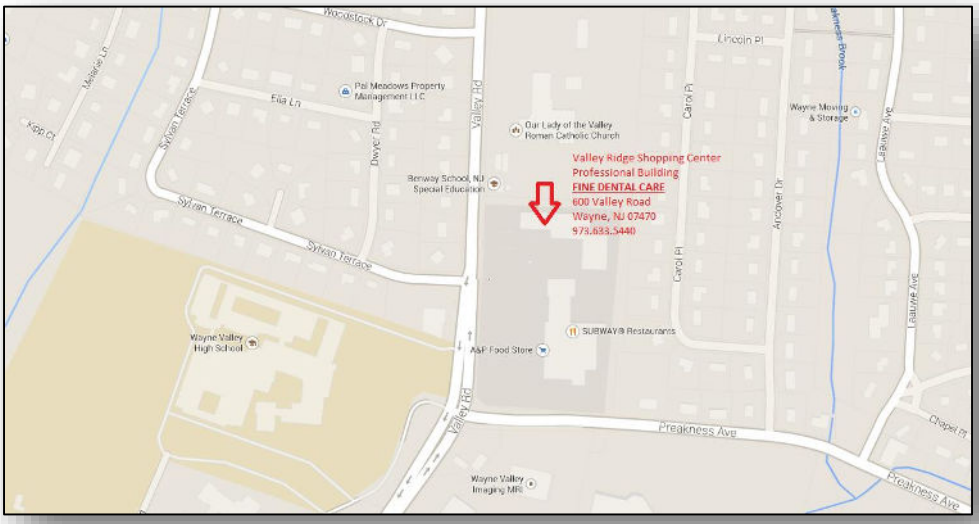
FINE
DENTAL CARE

600 Valley Road
Wayne, NJ 07470
973.633.5440

Bruce S. Fine, DDS



Greetings from Fine Dental Care! We look forward to meeting you on your first visit with us. We would appreciate it greatly if you take the time to complete the attached registration forms prior to your appointment. This will allow us to maximize your reserved time.

We are located on Valley Road, across from the municipal complex and Wayne Valley High School. We are in the Valley Ridge Shopping Center. The A&P is on one end and our professional building is on the other. Parking is located on site. We are on the ground floor of the professional building, down a short flight of stairs. (There is no elevator.)

If you have dental Xrays that were taken in the last three years, please bring them with you to your appointment, or have them e-mailed to us at ***info@finedentalcare.com***.

Don't forget your dental insurance card if you have coverage. We will scan it and return it to you immediately.

If you require antibiotic premedication before dental treatment, please contact your physician for a script prior to your appointment.

If you are unable to keep your appointment, please let us know at least 2 business' days in advance. Thank you.

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF IT'S FOR A DEPENDENT START HERE

1

DATE

NAME

SPOUSE

ADDRESS

CITY STATE ZIP

HOME PHONE # CELL PHONE #

BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

SOCIAL SECURITY NO. EMAIL ADDRESS

WHAT IS THE BEST WAY TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT?

DATE

NAME

ADDRESS

CITY STATE ZIP

HOME PHONE # CELL PHONE #

BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE

SOCIAL SECURITY NO.

DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH	DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH	DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY STATE ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS PHONE NO. EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS PHONE NO. EXT.

GETTING TO KNOW YOU 3

IS **ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?**

NAME: RELATIONSHIP:

REFERRED TO US BY

YOUR FORMER ADDRESS

CITY STATE ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY STATE ZIP

Please turn over and sign

PLEASE HELP US TO HELP YOU

In order for us to provide you with exceptional quality of care, we'd like to get to know you better. As providers, all of the following are important to us; however, we would like to know which is the most important to YOU.

Function ● Comfort ● Cosmetics ● Longevity

When considering having treatment done, which of these is your biggest obstacle?

Fear ● Time ● Budget ● No sense of urgency ● No trust

What is the most important quality for you in a relationship with a Doctor?

_____

_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. I will be responsible for all costs associated with collections or any unpaid balance including but not limited to, attorneys' fees and related costs of collections.

Patient_____ Date_____ Witness _____

Parent or Responsible Party _____ Relationship to Patient_____

DENTAL HISTORY

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care,
Please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____
_____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full Mouth X-rays**_____
What was done at your last dental visit?_____
_____
Previous Dentist's Name _____
Address _____
Telephone _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (electric tootbrush, toothpick, etc.)_____
Do you have any dental problems now? _____

On a scale of 1 – 10 how do you rate the appearance of your smile_____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
Do you:	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
Have a spouse who snores?	Yes	No
Daytime Sleepiness?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause		
Have you ever experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your breath?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Are you interested in a makeover of your teeth?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?		
Are you interested in having your teeth whiter?	Yes	No
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe _____		
_____		

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe _____
_____
_____

MEDICAL HISTORY

Patient Name	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? …….. Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address_____ City_____ State _____Zip_____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?..... Yes No
   If yes, please list name and dosage_____
4. Have you ever taken prescription medications for osteoporosis or cancer therapy?..... Yes No
   If yes, please list name, dosage and for how long_____
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance including jewelry? Yes No
   Please list_____
6. Have you been a patient in the hospital during the past five years?..... Yes No

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Snoring	Yes	No	Stroke	Yes	No	Liver Disease	Yes	No
Obstructive Sleep Apnea	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Arthritis/Rheumatism	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Have you lost or gained more than 10 pound in the past year? …… Yes No
9. Do you have or have you had any disease, condition, or problem not listed? …….. Yes No
10. **Women:** Are you: **Pregnant?** Yes,___months **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby consent that video and/or photographs be taken by Dr. Fine and staff for inclusion in my dental records, for purpose of illustration, publication, law enforcement requests, publicity or ad campaigns, or any other purpose deemed appropriate.

Patient/Guardian Signature_____ Date _____

Email Address_____

History Review

Dentist Signature_____ Date _____

Our General Office Policy

Fine Dental Care strives to bring its patients the most progressive dentistry available. We pride ourselves in attending frequent continuing education programs, using state-of-the-art equipment and techniques, and caring for each patient as if you are family. Our staff treats our patients as we would like to be treated.
We welcome all questions so that our patients are involved and informed before, during, and after each visit.

APPOINTMENTS

Our office makes every attempt to honor the time reserved for your scheduled appointment. When caring for people, it is sometimes impossible to be on schedule. On occasion, emergencies arise or unforeseen circumstances complicate an otherwise routine treatment. At these times it is still our priority to deliver quality dentistry even if it means getting off schedule. We respect your busy schedule and we will notify you with as much notice as possible if an unforeseen circumstance threatens the promptness of your appointment.

BROKEN APPOINTMENTS

We ask that you respect our time and schedule and give at least 48 weekday-hours' notice for appointments that cannot be kept.

However, if an appointment is broken with less than 24-hours' notice we reserve the right to charge a $50 per hour cancellation fee. Any subsequent cancellations will result in termination of treatment in this office. In fairness to all patients, we will not reschedule a missed appointment during prime hours (4-7 p.m.). Due to the great demand for prime-time appointments your cooperation in this matter is greatly appreciated.

FINANCIAL RESPONSIBILITY

Please initial: _____

All fees incurred for dental services are the responsibility of the patient (or legal guardian). If you are fortunate to have dental insurance benefits to assist your payment for services rendered, please be aware of your policy's benefits and limitations. We will make every effort to obtain your plan's coverage guidelines and assist you, but your insurance coverage is between you and your employer not between this office and your insurance carrier.

Payment is required at the completion of each visit. In addition to cash and personal checks we accept Visa, MasterCard, American Express, and Discover. Care Credit, a zero interest payment plan for up to twelve months, is also accepted.

For extensive rehabilitative cases a payment plan that extends throughout the course of treatment may be set up.

Those with insurance who indicate that benefits are to be sent directly to us will be responsible for their annual deductible and estimated co-payment at the time of the visit. Any fees not covered by your insurance plan are also your responsibility.

For those with an insurance pre-determination of benefits, you will be responsible for the fees or portion of fees not covered as per the pre-determination for the specific services completed that day. A pre-determination of benefits is not a guarantee of future payment.

Balances remaining after insurance benefits have been received will be due upon the receipt of statement. A service charge of 1.5% (18% per annum) will be added to any open invoice after 30 days. We reserve the right to charge an attorney collection fee on any outstanding balance after 60 days.

DENTAL INSURANCE

Please initial: _____

We will gladly submit an insurance claim on your behalf—even if we are not participating in your specific plan.

Whenever possible, assignment of benefits directing the insurance company to send us the payment will be expected. Until we are certain that your insurance company will send us the check we will expect payment in full from you at each visit.

It is important for you to understand that dental insurance may not completely cover our office fees for services rendered. Some plans have limitations for categories of treatment and some plans expect you to pay a percentage of each fee. If you are unhappy with your insurance coverage please contact your employer with your concerns.

We will do our best to help you understand your dental benefits, and will work with your carrier to maximize benefits within your policies' limitations. Disputes over benefits paid or not paid will be between you and your carrier; related balances on your account will be due upon the receipt of our statement.

NOTE: Many insurance contracts provide an *alternate amalgam benefit* for restorations (fillings) on posterior (back) teeth. If your contract contains this specification you will have a higher out-of-pocket expense for tooth colored restorations on posterior teeth. We do not place toxic mercury restorations.

DENTAL EMERGENCIES

Please initial: _____

There is 24-hour emergency coverage. Please call the regular office number to be routed to the dentist on call.

HIPAA 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 (MM/DD/YR), 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 $5.00 for each page, $75.00 per hour for staff time to locate and 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: *Linda Good*
Telephone: *973-633-5440*

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)