Welcome,

So that we may provide you with the best possible care, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help. Amit Vora, D.D.S.

Name: _____ Spouse's Name _____

(Please Circle One) Female Male (Please Circle One) Minor Single Married

Birthdate: _____ Age: _____ SS #: _____ Spouse's D.O.B. _____

Home Address: _____ Email: _____

City, State, Zip: _____ Home Phone: _____

Employer's Name: _____ Cell Phone: _____

Employer's Address: _____ Bus. Phone: _____

General Dentist: _____ # of Years You've Been Under His/Her Care: _____

Is the patient covered by Dental Insurance? Yes ☐ No ☐

Dental Insurance Information	**Secondary Dental Coverage**
Insured's Name:	Insured's Name:
SS #: Employer:	SS #: Employer:
Ins. Co. Name:	Ins. Co. Name:
Ins. Co. Address:	Ins. Co. Address:
Patient I.D. #:	Patient I.D. #:
Group #:	Group #:
Relationship to Patient:	Relationship to Patient:

Note Due to changing insurance rules and regulations, benefits, and deductibles, we are only able to approximate your insurance coverage. If your insurance pays more than expected you will be credited with the difference. If your insurance company pays less than expected, you will be billed the difference. Final responsibility for payment rests with the person responsible for your account.

Signature: _____ Date: _____ Relationship to Patient: _____

Patient Medical History - (If you answer YES to any of the following questions, please explain.)

Have you been a patient in a hospital in the past 2 years? ☐ No ☐ Yes _____

Have you ever had a major operation or any serious illnesses? ☐ No ☐ Yes _____

Have you ever had general anesthesia? ☐ No ☐ Yes _____

Have you been treated by a physician in the past 2 years? ☐ No ☐ Yes _____

If currently under the care of a doctor, please describe the condition being treated. _____

What is the name of your primary physician? _____ City located in? _____

Date of your last visit: _____ Reason for last visit: _____

For Women: Are you taking birth control pills/hormones? Y N Are you nursing? Y N

Are you pregnant? Y N (If yes, week #: _____)

(complete other side)

Medical Listing - *Do you have or have you had any of the following?*

Please check off any that apply.

____ Abnormal Bleeding	____ Emphysema	____ Kidney or Bladder Problems
____ AIDs/HIV+	____ Epilepsy or Seizures	____ Liver Disease/Disorder
____ Anemia	____ Glaucoma or Eye Disorders	____ Psychiatric or Psychological Care
____ Anxiety/Nervous Disorder	____ Hemophilia	____ Radiation (X-Ray) Treatment
____ Arthritis/Rheumatism	____ Hepatitis A (Infectious)	____ Sinus Problems
____ Artificial Bones or Joints	____ Hepatitis B (Serum)	____ Skin Disease or Rashes
____ Asthma	____ High Blood Pressure	____ Stomach Problems or Ulcers
____ Cancer or Chemotherapy	____ Low Blood Pressure	____ Thyroid Problems or Pills?
____ Diabetes	____ Hypoglycemia	____ Tuberculosis (TB)
____ Diet (Special or Restricted)?	____ Jaundice?	____ Venereal Disease

____ Artificial Heart Valve	____ Heart (Cardiac) Pacemaker	____ Chest Pains	**(For Women Only)**
____ Congenital Heart Defect	____ Heart Murmur or Valve Prolapse	____ Heart Attack	____ Premature Birth
____ Fainting or Dizziness	____ Rheumatic or Scarlet Fever	____ Stroke	____ Low Birthweight Babies

Do you have or have you had any disease, condition or problem not listed? (Please explain)

Are you taking or have you taken any medication for Osteoporosis? (Please explain)

Medications & Substances - *Are you taking (or have you ever taken) any of the following medications?*

Please check off any that apply.

____ Antibiotics or Sulfa Drugs	____ Blood Pressure Medicine	____ Recreational Drugs
____ Anticoagulants (blood thinners)	____ Cortisone (steroids)	____ Tranquilizers/Sedatives
____ Aspirin	____ Pain Medications	____ Weight Loss (Diet Pills)

Please list all medications, drugs or pills you are now taking (or have taken recently): _____

_____

Are you sensitive or allergic to any particular medications?:
(Including; Aspirin, Empirin, Demoral, Penicillin, Codeine, Novacaine, Mycin, or Sulfa) _____

_____

Dental Questions

1. Have you ever been treated for periodontal disease?	Yes ____	No____
2. Is there a history of periodontal disease or dentures in your family?	Yes ____	No____
3. Do you have sensitive teeth?	Yes ____	No____
4. Do you have bleeding gums?	Yes ____	No____
5. Have you noticed any gum recession?	Yes ____	No____
6. Are you aware of loose teeth?	Yes ____	No____
7. Are you aware of breath problems?	Yes ____	No____
8. Have you noticed your bite changing or your teeth shifting?	Yes ____	No____
9. Do you clench or grind your teeth at any time?	Yes ____	No____
10. Do you have habits such as biting on toothpicks, pens, etc?	Yes ____	No____
11. Do you have difficulty in chewing your food?	Yes ____	No____
12. Do you have pain in or near your ears?	Yes ____	No____
13. Have you ever had orthodontic treatment?	Yes ____	No____
14. Would you like to improve the appearance of your teeth?	Yes ____	No____
15. Do you suffer frequent or severe headaches?	Yes ____	No____
16. Have you ever had severe pains or injury of your head or face?	Yes ____	No____

Present Complaint:

Patient Signature: _____ **Date** _____

EDISON PERIODONTICS & IMPLANTOLOGY

Amit Vora, D.D.S.
N.J. Spec. #5644
Board Certified

Mediplex, Suite 306
98 James Street
Edison, New Jersey 08820

Ph (732) 494-2444/Fax (732)494-5730

Thank you for coming to our office for periodontal care. The following is a statement of our financial & missed appointment policies. Please read & sign prior to treatment.

Payment on Initial Day of Exam:
All patients without insurance are expected to pay for services when rendered.
Claims will be submitted for patients with insurance.

Regarding Insurance Assignment:
Most insurance plans will permit the direct assignment of your benefits to our office. We accept insurance assignment and your out of pocket expense will only be what insurance does not cover. These can include: co-payments, deductibles and exceeding yearly maximums. Patients are required to pay their portion the day services are rendered.

Our office will make every effort to collect appropriate payment from your insurance company. However, if your insurance company fails to make payment within 120 days, the balance will become your responsibility.

For your convenience we accept: Cash, Checks, Visa, and MasterCard.
We also offer patient financing through Care Credit if you qualify. (You may inquire at the front desk.) This is a health care finance program to provide you with the resources to meet your dental needs.

There will be a $25.00 charge for all returned checks.

An 18% monthly charge will apply (with a minimum of $10.00) to all accounts 90 days past due.

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the Practice/Office may contact me/us as described above.

Missed Appointments:
If you cannot make your appointment, please give us as much advance notice as possible so as to avoid a missed appt. charge. If notification is received 48 hours in advance of a surgical appointment or 24 hours in advance of a non-surgical appointment there will be no Missed Appointment Charge.

Missed appointment charges are 25% of the appointment fee.

_____ Date: _____

Signature of patient or responsible party

EDISON PERIODONTICS & IMPLANTOLOGY

AMIT VORA, DDS

MEDIPLEX – SUITE 306
98 JAMES STREET
EDISON, NJ 08820

Phone: (732) 494-2444 Fax: (732) 494-5730

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have read and acknowledged 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)

_____

(A copy is available for your records if needed)

AMIT VORA, DDS

EDISON PERIODONTICS & IMPLANTOLOGY

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 ___/___/___, 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.

Health 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 of 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.

Amit Vora, D.D.S.
Periodontics & Dental Implants

WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. You may also have special needs for treatment given your medical history. So that we can provide you with the best possible care, please check off the statements that apply to you. Sincerely, Dr. Vora

Name: _____ **Date:** _____

		Yes	No
1.	I am nervous being in a dental chair.	_____	_____
2.	I have had a bad experience in a dental office.	_____	_____
3.	I sometimes get dizzy lying back in a dental chair.	_____	_____
4.	I have had difficulty with gagging or suctioning.	_____	_____
5.	I would like to take breaks during long appointments.	_____	_____
6.	My teeth or gums are very sensitive.	_____	_____
7.	I don't like dental noises such as drilling or suctioning.	_____	_____
8.	I don't like shots (or have had a bad experience with them).	_____	_____
9.	I would like extra care to relieve pain.	_____	_____
10.	I am not comfortable being lectured to by doctors.	_____	_____
11.	I will need to relay what you tell me to my spouse or another.	_____	_____
12.	I have concerns about appointment scheduling.	_____	_____
13.	I have concerns about the appearance of my teeth or smile.	_____	_____
14.	I have concerns about eating, chewing, or bad breath.	_____	_____
15.	I have concerns about insurance or finances.	_____	_____
16.	I have another question or concern. (Please write it below.)	_____	_____

_____

17. Please check off if you (or a family member) have any history of the following:

	Yourself	*Parents*	*Grandparents*
A. Alzheimer's Disease	____	____	____
B. Blood Cancer	____	____	____
C. Diabetes	____	____	____
D. Heart Attack	____	____	____
E. Heart Disease	____	____	____
F. Kidney Cancer	____	____	____
G. Lung Cancer	____	____	____
H. Lung Disease	____	____	____

	Yourself	*Parents*	*Grandparents*
I. Obesity	____	____	____
J. Osteoporosis	____	____	____
K. Pancreatic Cancer	____	____	____
L. Premature Childbirth	____	____	____
M. Stroke	____	____	____
N. Tongue Cancer	____	____	____
O. Other Cancers	____	____	____
P. Tooth Loss/Dentures	____	____	____

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