# WELCOME TO CHAPEL HILL DENTAL ARTS

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health

Date _____

**PATIENT INFORMATION**

Cell Phone _____

Name _____ Home Phone _____

Last First Initial Work Phone _____

E-Mail _____ SS# _____

Address _____

City _____ State_____ ZIP _____

Sex ☐M ☐F Age _____ Birth Date _____/_____/_____☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Driver's License# _____

Referral _____ Emergency Contact _____ Phone_____

**PRIMARY INSURANCE**

Person Responsible for Account_____

Last First Initial

Relation To Patient _____ Birth Date _____/_____/_____SS # _____

Address (*if different than patient's)* _____

City _____ State_____ ZIP _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Group # _____ Subscriber SS# _____

Name of other Dependents Covered Under This Plan _____

**ADDITIONAL INSURANCE**

Is Patient Covered by Additional Insurance ☐Yes ☐No

Person Responsible for Account_____

Last First Initial

Relation To Patient _____ Birth Date _____/_____/_____SS # _____

Address (*if different than patient's)* _____

City _____ State_____ ZIP _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Group # _____ Subscriber SS# _____

Name of other Dependents Covered Under This Plan _____

**DENTAL HISTORY**

Reason for Today'sVisit _____
Former Dentist _____
Address _____
Date of Last Dental Care _____ Date of Last Dental X-Rays _____

Check if you have had problems with any of the following

| | | |
|---|---|---|
| ☐Bad Breath | ☐Grinding Teeth | ☐Sensitivity to Hot |
| ☐Bleeding Gums | ☐Loose Teeth or Broken Fillings | ☐Sensitivity to Sweets |
| ☐Clicking or Popping Jaw | ☐Periodontal Treatment | ☐Sensitivity when Biting |
| ☐Food Collection between Teeth | ☐Sensitivity to Cold | ☐Sores/Growths in Mouth |

How often do you floss _____ How often do you Brush _____

**DENTAL HISTORY**

Physician's Name _____ Date of Last Visit_____

Have you had any serious illness or operations ☐No ☐Yes – Approximate Dates _____
Check if you have had problems with any of the following:

| | | | |
|---|---|---|---|
| ☐Aids | ☐Cortisone Treatments | ☐Hepatitis | ☐Rheumatic Fever |
| ☐Anemia | ☐Cough, Persistent | ☐High Blood Pressure | ☐Scarlet Fever |
| ☐Arthritis, Rheumatism | ☐Cough up Blood | ☐HIV Positive | ☐Shortness of Breath |
| ☐Artificial Heart Valves | ☐Diabetes | ☐Jaw Pain | ☐Skin Rash |
| ☐Artificial Joints | ☐Epilepsy | ☐Kidney Disease | ☐Stroke |
| ☐Asthma | ☐Fainting | ☐Liver Disease | ☐Swelling of Feet/Ankles |
| ☐Back Problems | ☐Glaucoma | ☐Mitral Valve Prolapse | ☐Thyroid Problems |
| ☐Blood Disease | ☐Headaches | ☐Nervous Problems | ☐Tobacco Habit |
| ☐Cancer | ☐Heart Murmur | ☐Pacemaker | ☐Tonsillitis |
| ☐Chemical Dependency | ☐Heart Problems | ☐Psychiatric Care | ☐Tuberculosis |
| ☐Chemotherapy (Describe) | _____ | ☐Radiation Treatment | ☐Ulcer |
| ☐Circulatory Problems | ☐Hemophilia | ☐Respiratory Disease | ☐Venereal Disease |

List medications you are taking _____

Allergies _____

**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 _____'s dental needs
2. Upon such diagnosis, I authorize the 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 entails 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.

_____

Patient Date

# ASIM R. ZAIDI, DMD

# CONSENT FOR USE AND DISCLOSURE OF HELATH INFORMATION

**PATIENT CONSENT**

NAME _____

ADDRESS _____

TELEPHONE _____

E-MAIL _____

TO THE PATIENT – PLEASE READ CAREFULLY

Purpose of consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may pertain to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including revisions at any time by contacting Asim R. Zaidi, DMD 429 Highway 35 Red Bank NJ 07701 732-345-8460.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this consent form. I understand that by signing this form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE: _____ Date: _____

# *CHAPEL HILL DENTAL ARTS*

# *BROKEN APPOINTMENT POLICY*

When we give patients an appointment, we commit our time to them. Given the nature of dental treatment, we may commit several hours of our staff and dentist time for any given appointment. Therefore, we consider that when patients accept an appointment they have entered a contractual agreement to honor our time.

Nevertheless, we understand that there are times when circumstances beyond an individual's control may necessitate cancellation of an appointment. In those circumstances, we request the courtesy of 48 hours' notice for cancellation so that we can schedule other patients who are waiting for necessary treatment.

We try to make allowances for unforeseen events that may take place in an individual's life. However, we are unable to maintain an efficient practice if patients break appointments on short notice or fail to show for appointments. Therefore, if patients have proven unreliable in keeping their appointments, it is our policy to request that they seek treatment elsewhere.

We request that you keep this in mind and that you choose appointment times that you are absolutely certain will not interfere with work or family obligations.

I have reviewed the policy on broken appointments

_____ _____

Signature Date