VINCENT M. IMMORDINO, D.M.D., P.A.
ALEC E. KEON, D.M.D.

GOLDEN CREST CORPORATE CENTER
2273 STATE HIGHWAY 33, SUITE 201
HAMILTON SQUARE, NJ 08690
TELEPHONE (609) 588-0666
FAX (609) 588-0421

Dear New Patient:

We would like to take this opportunity to welcome you to our practice and thank you for choosing us as your dental care provider. We appreciate your trust and look forward to providing you with the finest dental treatment available.

Your first visit to our office will consist of an Initial Exam, and any x-rays that are necessary. When possible, we ask that you arrive a few minutes early for your first appointment. This will enable you to fill out any paperwork necessary as well as allow us time to answer any questions or concerns you may have regarding treatment or insurance coordination.

Regarding finances, our fees are payable at the time of service. We will be happy to file all insurance paperwork on your behalf. With most insurance companies we are able to *estimate* your insurance's co-payment and deductible. Please keep in mind we can only *estimate* your insurance's co-payment. We do not guarantee benefits. Your insurance is a contract between you and the insurance company only. Our practice accepts cash, checks and all major credit cards for your portion of payment.

If a physician has ever informed you that you may have a prior history of a cardiac condition, joint replacement or any other condition that requires pre-medication for a dental visit, please contact our office or your family physician prior to your appointment with us.

Once again, on behalf of Drs. Immordino and Keon, thank you. We look forward to meeting you and providing you with a bright smile for many years to come.

WELCOME

Thank you for choosing our office. Please take a few minutes to fill out both sides of this form. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Security # _____
Last Name First Name Initial

Address _____ Cell _____

City _____ State _____ Zip _____ Phone _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

MEDICAL HISTORY

Physician's Name _____ Address _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N If yes, describe _____

_____

_____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (√) if you have had any of the following:

- ❑ AIDS
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints
- ❑ Asthma
- ❑ Atopic (allergy prone)
- ❑ Back problems
- ❑ Blood disease
- ❑ Blood transfusion
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Food allergies
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
  Describe _____
- ❑ Hemophilia/Abnormal Bleeding
- ❑ Herpes
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV positive
- ❑ Jaw pain
- ❑ Kidney disease or malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal, chemicals)
- ❑ Mitral valve prolapse
- ❑ Nervous problems
- ❑ Pacemaker/Heart Surgery
- ❑ Psychiatric care
- ❑ Rapid weight gain or loss
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Stroke
- ❑ Surgical implant
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease or malfunction
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Venereal disease
- ❑ _____
- ❑ _____

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last X-rays _____

Check (√) if you have had any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding or clenching teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? _____

Other information about your dental health or previous treatment _____

PLEASE COMPLETE BOTH SIDES

PRIMARY INSURANCE

Person Responsible for Account _____ _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc.Sec.# _____

Address (*if different from patient*) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ❑ Y ❑ N

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (*if different from patient*) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

AUTHORIZATION AND FINANCIAL POLICY

- I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of the benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that my insurance policy is a contract between myself and my insurance company, and that it is my responsibility to know my dental benefits.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

A 1.5% monthly service charge will be applied to balance carried over 60 days.

We realize that temporary financial problems may effect timely payment of your account.
If such problems occur, we encourage you to contact us promptly for assistance in the management of your account.
Charges may be applied for broken appointments and appointments cancelled without 24 hour advance notice. Thank you.

Signature _____ Date _____

Vincent M. Immordino, D.M.D., P.A. Alec E. Keon, D.M.D.
2273 State Highway #33 Suite 201
Hamilton Square, New Jersey 08690
609-588-0666

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 / 03, 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 $0. 75 for each page, $ 25.00 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.

Privacy Contact Officer: Vincent M. Immordino, D.M.D.

Telephone: 609-588-0666 Fax: 609-588-0421

Address: State Highway #33 Suite 201
Hamilton Square, New Jersey 08690

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received 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)

_____

_____

_____