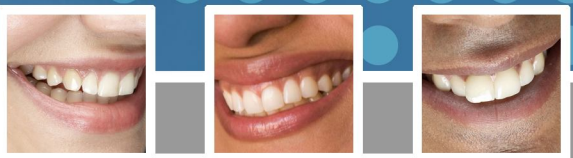
Mid-Atlantic Periodontic, P.C.
555 Iron Bridge Road
Suite #14
Freehold NJ 07728
(732)409-0090



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Name of doctor, person, office, or other source referring you to our practice:

_____

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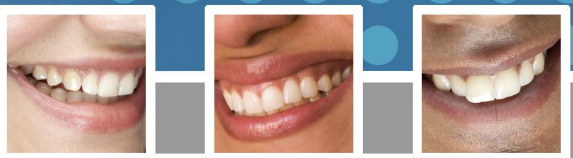

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

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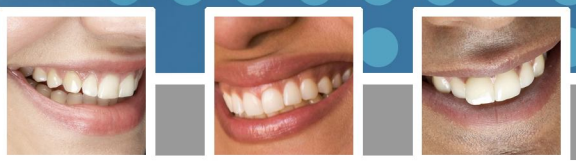

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ ____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ ____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ ____ _____

City State Zip Code

Primary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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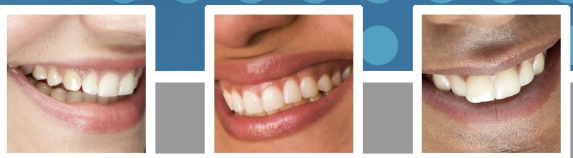

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ ____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ ____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ ____ _____

City State Zip Code

Secondary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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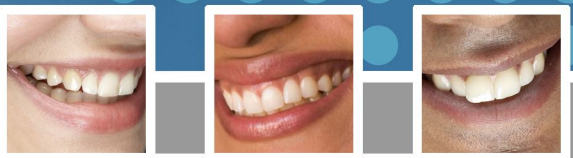

Consent for Services

CASES WHERE INSURANCE IS INVOLVED
We will try to verify your insurance coverage. When this is done, we will approximate all deductible, co-pay, and any portion of the bill you will be responsible for. We do this as a courtesy to our patients. However, it is your responsibility to understand how your insurance plan works. We will require that you pay your portion of the bill at the time of treatment. We will be happy to submit any and all insurance forms necessary. If in the event after we have been paid by your insurance, there is still a balance due, we will require that you pay that within 15 days of receiving a statement from our office. If in the rare event you have overpaid, we will give you the same courtesy we expect. We will reimburse you within 15 days after your request. Because we can sometime only approximate from the information we are give from your insurance company, these sometimes occur.

Please remember that, your dental insurance is a contract between you (or your employer) and the insurance company. We are not a part to that agreement.

As your care provider, our relationship is with you, not your insurance company. We will recommend the best possible treatment for you, regardless of coverage limitations. Keep in mind that insurance companies stay in business by minimizing payment of benefits.

FORMS OF PAYMENT WE OFFER:
Cash Checks Visa Master Card Discover American Express CitiHealth Card

There is a fee of $30.00 for returned checks. In the event the use of a collection agency is required, an additional fee of $50.00 will be applied for collections management.
There is a $75.00 charge for a missed appointment or if 24 hours notice is not given. This fee is not covered by any of the insurances.
Thank you and if you have any questions please feel free to ask the receptionist, she will be happy to help you.
I have read, understand, and agree to the provisions of this financial policy.
Fees are in effect for 6 months.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

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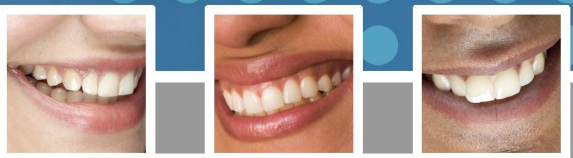

DENTAL HISTORY

Reason for Today's Vistit

Date of last dental care and what was done?

Name of your general dentist and how long you have been seeing him/her?

Check if you have had problem with any of the following:

- ☐ Bad breath
- ☐ Bleeding gum
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding
- ☐ Loose teeth or broken filling
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitive to hot
- ☐ Sensitive to sweets
- ☐ Sensitive when biting
- ☐ Sores or growth in your mouth

MEDICAL HISTORY

Have you had any serious illness or operation?

◯ Yes ◯ No

If yes, describe

Have you ever had a blood transfusion?

◯ Yes ◯ No

If yes, give approximate dates

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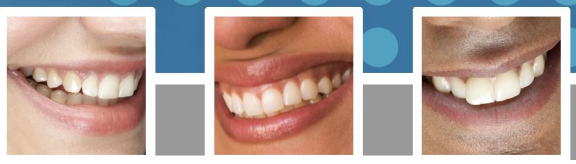

Check if you have or have had any of the following:

- [ ] Anemia
- [ ] Arthritis, Rheumatism
- [ ] Artificial Heart Valves
- [ ] Asthma
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Chemotherapy
- [ ] Circulatory Problems
- [ ] Cortisone Treatments
- [ ] Cough, Persistent
- [ ] Cough up Blood
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Jaw pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Diease
- [ ] Rheumatic Fever
- [ ] Shortness of Breath
- [ ] Skin Rash
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tobacco habit
- [ ] Tuberculosis
- [ ] Ulcer/Stomach Problem
- [ ] Venereal Disease

Mediactions.

List medications you are currently taking:

Allergies

List allergies (ie food, medication, etc)

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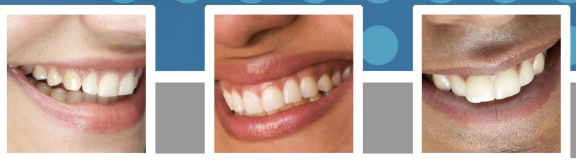

Signature: _____

Date: _____

Response Date: _____