Sewell Dental Care, LLC

sewelldentalcare.com | sewelldentalcare@gmail.com

Severan Professional Mews | 202-A Kings Way West • Sewell, NJ 08080 | (856)589-2298

Patient Information

Thank you for choosing our office for your dental care. We will strive to make your visits as convenient and pleasant as possible. 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) ___ (M) _____ (Preferred Name)

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

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

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

Emergency contact name and phone number:

_____

_____

Whom may we thank for referring you to our practice?

☐ Yellow Pages ☐ Internet ☐ Advertisement ☐ Other (name below):

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

_____

Responsible Party Information

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

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

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

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First M

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

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Medical Insurance:

Name of Insured: _____ _____ ___
Last First M

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

Insurance Plan Name: _____

Consent for Services

Many of you have a dental insurance plan that helps in covering a portion of the cost of dental care. There are many restrictions on what is paid based on yearly maximums, uncovered treatments, and disallowances. Whatever treatment Dr. Wu recommends is based on what he feels is best for you and may not be what an insurance company approves to minimize their costs. Due to this, only you and Dr. Wu can make the decision on what treatment will be best for you. Insurance companies generally base payment on the least costly procedure with the understanding that you are responsible for the difference in cost between the least expensive procedure and the recommended procedure.

We will gladly submit all the forms for you and accept the assignment of benefits if permitted by your insurer (meaning the insurance company will pay their portion directly to us). We request that you pay your co-pay at the time of service. If your insurer will not pay our office directly or you do not have insurance, we require that you pay the entire portion at the time of service. We estimate benefits as carefully as possible but, due to the tens of thousands of constantly changing benefit plans, it is impossible to guarantee the amount the insurance company will actually pay. Many people also have double coverage but, due to the ever changing insurance company rules, we will only accept assignment of benefits from your primary carrier.

We can answer questions and help you understand your benefits, but any disputes with your insurer must be negotiated by you. Treatment started must be completed otherwise insurers do not consider themselves liable for payment.

We have several payment options and interest free financing for more lengthy treatments so you can choose what is best for you with less financial worry.

☐ * **I have read the above and agree to pay all amounts estimated to be due by me at the time of service and to assign directly to Dr.Wu all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I will be charged a finance charge of 1.5% per month for all unpaid balances over 60 days and that I may be charged for any missed appointment if I haven't provided 24 hours notice of cancellation.**

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

Signature _____ **Date** _____

Relationship to Patient: *

_____

_____

_____

Response Date: ____/____/_____

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Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

What is the reason for your dental visit today?

Prior Dentist's name, address, & phone number:

Date/type of last dental care/date of last dental xrays

Frequency of brushing/flossing

Please check if you currently have or had any of the following:

- ☐ Painful teeth
- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Sleep apnea
- ☐ Clicking/Painful jaw
- ☐ Biteguard
- ☐ Dental treatment complications
- ☐ Food collection between teeth
- ☐ Clenching/Grinding
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Mouth ulcers
- ☐ Snoring

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth or smile, what would it be?

Medical History

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address, & phone number:

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

☐ Anxiety/Depression	☐ Anemia	☐ Angina	☐ Arthritis/Rheumatoid/Osteo
☐ Artificial Joints	☐ Artificial Heart Valve	☐ Asthma	☐ Back/Neck problems
☐ Bleeding disorder/Hemophilia	☐ Blood disease	☐ Take blood thinners	☐ Breathing problems
☐ Cancer	☐ Chemotherapy	☐ Circulatory problem	☐ Colitis
☐ Diabetes	☐ Digestive disorder/Acid reflux	☐ Drug dependency	☐ Epilepsy/Seizure Disorder
☐ Eye disorders/glaucoma	☐ Headaches/Migraines	☐ Heart murmur/Valve prolapse	☐ Heart problems/Attack
☐ Hepatitis A, B, C	☐ High Blood Pressure	☐ HIV/AIDS	☐ Kidney Disorder/Dialysis
☐ Liver disease	☐ Neurologic disease/MS	☐ Osteoporosis meds	☐ Pacemaker/Defibrillator
☐ Radiation treatment	☐ Respiratory disease	☐ Rheumatic/Scarlet fever	☐ Skin rashes
☐ Steroid/Prednisone therapy	☐ Stroke	☐ Thyroid problems	☐ Tuberculosis
☐ Ulcers	☐ Autoimmune disease/lupus		

Please provide additional information for any check above or additional health concerns:

_____

_____

_____

_____

_____

Women Only: Are you pregnant? ○ Yes ○ No

Due date: _____

List any operations or surgeries:

_____

_____

Do you smoke or chew tobacco? ○ Yes ○ No

How many per day? _____

Do you drink alcohol?

○ None ○ Daily 1-2 drinks ○ Daily 3 or more drinks ○ Socially/Occasionally ○ Rarely

List medications you are currently taking:

_____

_____

_____

Name and number of pharmacy:

_____

_____

Allergies:

☐ None	☐ Ibuprofen/Aspirin	☐ Codeine/Narcotics	☐ Local Anesthetics
☐ Penicillin/Amoxilcillin	☐ Sulfa	☐ Latex	☐ Seasonal allergies/Hay-fever
☐ Imaging dyes (e.g. iodine)	☐ Other		

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment. I also understand that in extremely rare cases numbness of the lips may last months or even years due to a local anesthetic injection.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider.

Signed on next page

Authorization

☐ **By checking this box, and/or signing below, I acknowledge that I have read the above statement and agree to the contents.**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I will inform the office if there are any changes.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.
I understand that I am responsible for payment for all services rendered to me and /or my dependents, whether or not paid by insurance.

Signature _____ **Date** _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

☐ **By checking this box, I acknowledge that I have reviewed the notice of privacy practices.**

I have reviewed a copy of this office's Notice of Privacy Practices

Signature _____ **Date** _____

For Office Use Only
We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

◯ Individual refused to sign
◯ Communication barriers prohibited obtaining the acknowledgement
◯ An emergency situation prevented us from obtaining acknowledgement
◯ Other (Please Specify)

Response Date: ____/____/_____