We are excited that you made the commitment to improve your oral health and that you chose our office to help you.

YOUR FIRST VISIT

We want to get to know you better and understand your needs, and that means a thorough look at the health of your teeth and gums.

In order to recommend the best treatment to help you achieve your dental goals, it is important that we have the correct information to diagnose your current dental health.

To do this, your first visit with our office is scheduled to allow us to collect all the information we will need to guide your treatment.

You can expect a comprehensive oral exam, a complete series of x-rays and a full Periodontal evaluation including charting.

We do not believe in beginning any treatment without knowing the "problems", so we do not schedule any definite treatment until a complete diagnosis is established.

We are confident this approach will allow for a full treatment experience and a healthy and maintainable dental result.

We look forward to helping you create your profile!

Today's Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Middle Nickname

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail _____

Sex: ☐ Male ☐ Female Age ____ Birthdate _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient employed by _____ Business Address _____

Full time student? **YES** **NO** What college? _____ Whom may we thank for referring you? _____

PERSON RESPONSIBLE FOR ACCOUNT / PRIMARY DENTAL INSURANCE INFORMATION

Relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Spouse ☐ Other _____

Policy Holder's Name _____ Soc. Sec. # _____ Birthdate _____
Last Name First Name Middle

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employed by _____ Business Address _____ Work Phone _____

Dental Insurance Company _____
Company Name Address

Group # _____ ID # _____ Phone _____

ADDITIONAL/SECONDARY DENTAL INSURANCE INFORMATION

Is patient covered by another Dental insurance? ☐ Yes ☐ No

Relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Spouse ☐ Other _____

Policy Holder's Name _____ Soc. Sec. # _____ Birthdate _____
Last Name First Name Middle

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employed by _____ Business Address _____ Work Phone _____

Dental Insurance Company _____
Company Name Address

Group # _____ ID # _____ Phone _____

If the patient is a CHILD, please complete the following information:

Mother's Name _____ Soc. Sec. # _____ Birthdate _____
Last Name First Name Middle

Father's Name _____ Soc. Sec. # _____ Birthdate _____
Last Name First Name Middle

PATIENT REGISTRATION

OFFICE POLICY

We would like to take this opportunity to welcome you to SMILE CREATIONS, P.A.

In order for our office to treat you effectively, in all aspects of dental care, we ask that you review our office policies:

Payment is expected when treatment is rendered. If you are covered under an insurance plan, we will be happy to process your form at the time of your visit. Co-payments are due and payable at the time of treatment. For your convenience, we accept Visa, Master Card, Discover, American Express and CareCredit. If an extended payment plan is necessary, we offer the CareCredit payment option.

Quality dental care takes time. Your appointment is scheduled to allow for this time. If you are going to arrive late for your appointment, contact the office first, as there may not be adequate time left for your procedure and you may need to be rescheduled. There are times in our schedule when emergency care patients are seen. If this puts us behind schedule and this is an inconvenience to your schedule, we will be happy to reschedule your appointment.

Our time is as valuable to us a yours is to you, therefore, if it becomes necessary to cancel your appointment, please do so 24 hours ahead of time, otherwise, you will be billed for the broken appointment.

Successful dental care is a team effort between the dentist and the patient. Our responsibility is to provide quality dental care. Your failure to maintain good oral hygiene and regular recare visits may cause premature breakdown of dental restorations, for which we cannot be responsible.

I have read and understand the above policies.

DATE: _____ SIGNATURE: _____

SIGNATURE ON FILE

PATIENT'S NAME _____
Last First Middle

I hereby authorize payment directly to **SMILE CREATIONS, PA** of the dental benefits otherwise payable to me.

SIGNATURE of INSURED PERSON _____ DATE _____
Signature is valid, unless revoked by me.

Nicholas Bencie, D.M.D., F.A.G.D. OR Charles Liu, D.D.S. OR Robert Malfara, D.M.D.
Is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advise, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract in force.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

OFFICE POLICY & SIGNATURE ON FILE

THE COMMONS AT BREWSTER • 630 S. BREWSTER RD, SUITE A-2 • VINELAND, NJ 08360 • BY APPT (856) 692-0060 • FAX (856) 692-0382

Patient's Name _____ Date of Birth _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU ANSWER YES TO ANY QUESTION, PLEASE EXPLAIN IN THE COMMENTS BOX.

COMMENTS

1. Physician's name _____
   Address _____
2. Are you under a physician's care?..... YES NO
   Since when? _____ Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances?..... YES NO
   (If YES, please list medications in COMMENTS section)
5. Are you allergic to any medications or substances?(specify)..... YES NO
6. Do you have any other allergies?..... YES NO
7. Do you have any problems with penicillin, antibiotics, anesthesia or other medications?..... YES NO
8. Are you sensitive to any metals or latex?(circle one)..... YES NO
9. Are you pregnant or suspect you may be?..... YES NO
10. Have you ever been treated for or told you have heart disease?..... YES NO
11. Do you have a pacemaker or artificial valve replacement?..... YES NO
12. Have you ever had rheumatic fever?..... YES NO
13. Have you been diagnosed with MITRAL VALVE PROLAPSE or HEART MURMUR?(circle one)..... YES NO
14. Do you have high or low blood pressure?(circle one)..... YES NO
15. Have you ever had a serious illness or major surgery?..... YES NO
16. Have you ever had radiation or chemo therapy?..... YES NO
17. Do you have arthritis or rheumatism?..... YES NO
18. Do you have any artificial joints/prosthesis?..... YES NO
19. Do you have any blood disorders, such as anemia, leukemia, etc?... YES NO
20. Have you ever bled excessively after being cut or injured?..... YES NO
21. Do you have any stomach problems?..... YES NO
22. Do you have any kidney problems?..... YES NO
23. Do you have any liver problems?..... YES NO
24. Are you diabetic?..... YES NO
25. Do you have asthma?..... YES NO
26. Do you have epilepsy or seizure disorders?..... YES NO
27. Do you or have you had venereal disease?..... YES NO
28. Are you HIV positive?..... YES NO
29. Do you have AIDS?..... YES NO
30. Have you tested positive for hepatitis?..... YES NO
31. Do you or have you had T.B.?..... YES NO
32. Do you smoke, chew, use snuff or any other forms of tobacco?..... YES NO
33. Do you consume alcoholic beverages?..... YES NO
34. Do you habitually use controlled substances?..... YES NO
35. Have you had psychiatric treatment?..... YES NO
36. Do you have any disease, condition or problem not listed? If so, please explain:
    _____
37. Is there anything else we should know about your health that we have not covered in this form? _____
38. Would you like to speak to the Doctor privately about any problem?... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

1. Purpose of initial visit _____

_____

2. Are you aware of a problem? _____

_____

3. How long since your last dental visit? _____
4. What was done at that time? _____

_____

5. Previous dentist's name _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW, PLEASE WRITE 'DON'T KNOW' AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often? _____
8. Were dental x-rays taken?..... YES NO
9. Have you lost any teeth or have any teeth been removed?..... YES NO
10. Have they been replaced?..... YES NO
11. How have they been replaced?
    Fixed Bridge _____ Age _____
    Removable Bridge _____ Age _____
    Denture _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements?..... YES NO
14. Have you ever had any complications with previous dental treatment? YES NO
    If yes, explain _____
15. Do you clench or grind your teeth?..... YES NO
16. Does your jaw click or pop?..... YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear?..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?... YES NO
19. Does food get caught in your teeth?..... YES NO
20. Are any of your teeth sensitive to: HOT COLD SWEET PRESSURE
21. Do your gums bleed or hurt?..... YES NO
    When? _____
22. How often do you brush your teeth? _____ When? _____
23. Do you use dental floss?..... YES NO
    How often? _____
24. Are any of your teeth loose, tipped shifted or chipped?..... YES NO
25. Are you unhappy with the appearance of your teeth?..... YES NO
26. How do you feel about your teeth in general? _____
27. Do you feel your breath is offensive at times? ..... YES NO
28. Have you ever had gum treatment or surgery?..... YES NO
    What? _____
    When? _____
    Where? _____
29. Have you had any orthodontic work?..... YES NO
30. Do you have any questions or concerns?..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTAL HISTORY

Dental Information Release Form

HIPAA Release Form

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] **S**pouse_____ Phone_____

[ ] **C**hild(ren)_____ Phone_____

_____ Phone_____

_____ Phone_____

[ ] Other_____ Phone_____

[ ] Information is not to be released to anyone.

Signature of patient: _____ Date: _____

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ / _____ / _____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

#FM-0306 • Printed in U.S.A.

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.