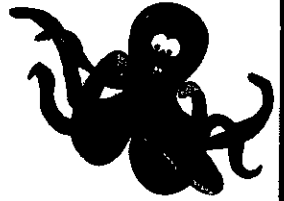


PATIENT INFORMATION (CONFIDENTIAL)



Patient's Name:

Home Address:

City:

State:

Zip:

DOB: / /

Sex:

Male

Female

SS #:

Cell Phone:

Home Phone:

Work Phone:

Email:

Drivers Lic:

Marital Status:

Married

Single

Divorced

Separated

Widowed

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

Name:

Whom may we thank for referring you?

Home Address:

City:

State:

Zip:

DOB: / /

Is this person currently a patient in our office?

Yes

No

PRIMARY INSURANCE INFORMATION

Name of Insured:

Relationship to Insured:

Self

Spouse

Child

Other

DOB: / /

Insured Social Security #:

Employer:

Insurance Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip:

DO YOU HAVE ANY ADDITIONAL INSURANCE?

IF YES, COMPLETE THE ADDITIONAL INFORMATION ON THE NEXT PAGE.

Yes

No

SECONDARY INSURANCE INFORMATION

Name of Insured:

Relationship to Insured:

Self Spouse Child Other

DOB: / /

Insured Social Security #:

Employer:
Address: _____
Address 2: _____
City, State, Zip: _____

Insurance Company:
Address: _____
Address 2: _____
City, State, Zip: _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MONOR:

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No
- Have you ever been hospitalized or had a major operation? Yes No
- Have you ever had a serious head or neck injury? Yes No
- Are you taking any medications, pills, or drugs? Yes No
- Do you take, or have taken, Phen-Fen or Redux? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

If you answered yes to any of the above, please explain:

Women: Are you: Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex
 Sulfa Drugs Local Anesthetics Other? _____

MEDICAL HISTORY

Do you have, or have you had, any of the following?

- | | | | | | |
|---------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| AIDS/HIV Positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breathing Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapsc | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug Addiction | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easily Winded | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive Thirst | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spina Bifida | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting Spells/Dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach Intestinal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genital Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack/Failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Trouble/Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had any serious illness not listed above? Yes No

Comments: Please list any disabilities:

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MONOR:

Date:

Notice of HIPAA Policies and Procedures

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 is important to us.

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. This notice takes effect immediately and will remain in effect until we replace it. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your health information to obtain payment for services we provide to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operation: 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.

To your Family and Friends: We may disclose your health information to a family member, friend or other person (please see next page) to the extent necessary to help with your healthcare or with payment for your healthcare.

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. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement for your best interest in allowing a person to pick up dental supplies, x-rays or other similar forms of health care information.

Marketing Health-Related Services: We will not use your health information for marketing without your written authorization.

Required by Law: We may use or disclose your health information when we are required 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.

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: Under federal law, we can only release your personal health information to those directly involved in providing your care; however, you have the right to grant access to your personal medical or billing information to other individuals or organizations of your choice. If you choose to do so, we require a written authorization.

Acknowledgement of Receipt of HIPAA Policies and Procedures

Corrie J. Crowe, DDS

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

Corrie J. Crowe, 1793 Springdale Road, Cherry Hill NJ 08003

Patient Name _____

Date of Birth _____

Under the requirements of HIPPA we are not allowed to give information to anyone without the patient's / parent's / guardian's consent. If you wish to have your / patient's dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Dr. Corrie Crowe to release dental and/or billing information to the following individual(s):

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the pretexted health / billing information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____

Date: _____

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 856-258-4025

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____

Patient Signature: _____

Date: _____

PATIENT SCREENING FORM

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you/they have a cough?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you/they in contact with any confirmed COVID-19 positive patients?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your/their age over 60?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

PATIENT SCREENING FORM

Thank you for your continued trust in our practice. As with the transmission of any communicable diseases like the cold or flu, you may be exposed to COVID-19 (Coronavirus) at any time or any place. Rest assured that we have always followed the infection control policies as stated by the state and federal regulations. We use universal precautions and the proper PPE to limit the transmissions of all diseases in our office and will continue to do so.

Despite our careful attention to sterilization, disinfection, and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. Social Distancing nationwide has reduced the transmission of the Coronavirus.

Although we have taken measures to provide social distancing in our practice due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental assistants and hygienist and sometimes other patients at all times. Exposure to the virus is very unlikely.

Do you accept the risk and consent to treatment?

YES

NO

Patient's signature/parent or guardian: _____

Date: _____