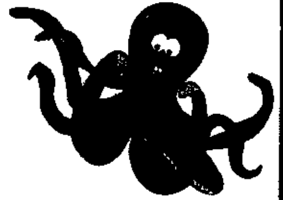
PATIENT INFORMATION (CONFIDENTIAL)



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)

Whom may we thank for referring you?

Name:

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:

Address: ______________________________

Address 2: ______________________________

City, State, Zip: ______________________________

Insurance Company:

Address: ______________________________

Address 2: ______________________________

City, State, Zip: ______________________________

DO YOU HAVE ANY ADDITIONAL INSURANCE?

☐ Yes ☐ No

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

SECONDARY 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: ______________________

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?

Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Angina	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Stomach Intestinal Disease	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Genital Herpes	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ 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 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)?	☐ YES ☐ NO	☐ YES ☐ NO
Are you/they having shortness of breath or other difficulties breathing?	☐ YES ☐ NO	☐ YES ☐ NO
Do you/they have a cough?	☐ YES ☐ NO	☐ YES ☐ NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ YES ☐ NO	☐ YES ☐ NO
Have you/they experienced recent loss of taste or smell?	☐ YES ☐ NO	☐ YES ☐ NO
Are you/they in contact with any confirmed COVID-19 positive patients?	☐ YES ☐ NO	☐ YES ☐ NO
Is your/their age over 60?	☐ YES ☐ NO	☐ YES ☐ NO
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ YES ☐ NO	☐ YES ☐ NO
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ YES ☐ NO	☐ YES ☐ 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 you 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: ____________________________

Dr Corrie Crowe, DDS. FAPD
(856)258-4025
www.drcrowedentistry.com

1793 Springdale Road
Cherry Hill, NJ 08003

FINANCIAL POLICY

FINANCIAL POLICY
Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

INSURANCE
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request.

PAYMENT
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT
Full payment for services is expected at the time of service. If insurance benefits apply, THE ESTIMATED PATIENT CO-PAYMENT AND OR DEDUCTIBLES are due at time of service, unless other arrangements are made.

UNPAID BALANCE
Any unpaid balance over 90 days old will be subject to a monthly interest charge of 1%(APR 12%). If payment is delinquent, the patient will be responsible or payment collection, attorney fees and court costs associated with the recovery of the monies due on the account.

PROPERTY DAMAGE
The patient, guardian or caregiver will be held financially responsible for any damages to property that may occur due to careless or intentional actions that may lead to the damage.

MISSED APPOINTMENTS
Unless we receive 48 hours notice, we reserve the right or charge a $50 fee for any missed or canceled appointments.

I have read, understand, and agree to the terms and conditions of this Financial Agreement

____ ______________

Patient/Parent/Legal Guardian Signature Date