TIME 05:30 PM DATE 11/4/2014

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer:

Address:

Address 2:

City, State, Zip:

Ins. Company:

Address:

Address 2:

City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer:

Address:

Address 2:

City, State, Zip:

Ins. Company:

Address:

Address 2:

City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 5:26 PM

Drs. Moran _Zemla

Eaglesoft Medical History

Date 11/4/2014

Patient Name: Birth Date: Date Created:

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	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

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

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

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

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________

John J. Moran, D.M.D.
Zachary S. Zemla, D.M.D.
PREVENTIVE AND RESTORATIVE DENTISTRY

400 HARRISON AVENUE
HARRISON, NJ 07029
TELEPHONE (973) 484-0979
FAX (973) 484-9608

353 MONMOUTH ROAD
WEST LONG BRANCH, NJ 07764
TELEPHONE (732) 870-8660
FAX (732) 870-2088

DEAR PATIENT,

EFFECTIVE APRIL 14TH, 2003, ALL HEALTH CARE FACILITIES AND PHYSICIANS SHALL BE REQUIRED TO COMPLY WITH THE NEW FEDERAL(HIPPA-HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) LAWS CONCERNING HOW YOUR NEW FEDERAL(HIPPA-HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) LAWS CONCERNING HOW YOUR HEALTH INFORMATION IS SHARED, STORED AND UTILIZED.
YOUR PRIVACY IS VERY IMPORTANT TO US. PLEASE READ THE ENCLOSED PRIVACY POLICY TO SEE WHAT WE ARE DOING TO PROTECT IT.

NOTICE OF PRIVACY PRACTICE

WE WILL KEEP YOUR HEALTH INFORMATION CONFIDENTIAL, USING IT ONLY FOR THE FOLLOWING PURPOSES:

TREATMENT: *YOUR PROTECTED HEALTH INFORMATION(PHI) MAY BE USED TO DISCLOSE TO OTHER PHYSICIANS, REFERRING DENTISTS, DENTAL LABORATORIES, PHARMACIES OR OTHER HEALTH CARE PROFESSIONALS INFORMATION IN EVALUATING AND PROVIDING YOU PROPER TREATMENT.*

PAYMENT: *YOUR PHI MAY BE USED TO SEEK PAYMENT FOR SERVICES WE RENDERED TO YOU FROM INSURANCE COMPANIES, CLAIMS FILED ELECTRONICALLY, OR PARTIES RESPONSIBLE FOR PAYMENT.*

HEALTH CARE OPERATIONS: *YOUR PHI MAY BE USED DURING EVALUATIONS OF OUR STAFF, LICENSE RECREDENTIALING, CERTIFICATION, APPOINTMENT REMINDERS SUCH AS POSTCARDS, TELEPHONE COMMUNICATION, AUDITS BY INSURANCE COMPANIES, OR RELATED AGENCIES FOR QUALITY ASSURANCE AND COMPLIANCE REVIEWS.*

ABUSE OR NEGLECT: *WE MAY NOTIFY PROPER AUTHORITIES IF WE BELIEVE YOU ARE A VICTIM OF VIOLENCE, ABUSE OR NEGLECT AS REQUIRED BY LAW.*

PUBLIC HEALTH/NATIONAL SECURITY: *WE MAY DISCLOSE YOUR PHI FOR PATIENT SAFETY TO REPORT PROBLEMS WITH PRODUCTS, MEDICATIONS, DISEASE/INFECTION EXPOSURE, INJURY OR DISABILITY.*

REQUIRED BY LAW: *WE MAY USE YOUR PHI WHEN REQUIRED BY STATE AND FEDERAL LAW.*

FAMILY, FRIEND AND CAREGIVERS: *WE MAY USE YOR PHI WITH THOSE YOU TELL US WILL BE HELPING YOU WITH YOUR HOMECARE, TREATMENT, MEDICATIONS, OR PAYMENT.*

PATIENTS RIGHTS

THIS DESCRIBES YOUR RIGHTS TO YOUR HEALTH INFORMATION:

RESTRICTIONS: *YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS AND DISCLOSURES OF YOUR HEALTH INFORMATION. OUR OFFICE WILL MAKE EVERY EFFORT TO HONOR REASONABLE RESTRICTIONS.*

CONFIDENTIAL COMMUNICATIONS: *YOU HAVE THE RIGHT TO REQUEST THAT WE COMMUNICATE WITH YOU YOUR PHI PRIVATELY IN PERSON, PHONE, AND BY VIA MAIL.*

INSPECT AND COPY YOUR HEALTH INFORMATION: *YOU HAVE THE RIGHT TO READ, REVIEW, AND COPY YOUR HEALTH INFORMATION. PLEASE NOTE THAT WE MAY CHARGE YOU A REASONABLE FEE TO DUPLICATE YOUR RECORDS.*

AMENDMENT: *YOU HAVE THE RIGHT TO UPDATE/AMEND YOUR HEALTH CARE INFORMATION IF YOU FEEL IT IS INACCURATE. YOUR REQUEST MUST BE IN WRITING AND MUST INCLUDE AN EXPLANATION OF WHY AN AMENDMENT IS NEEDED. UNDER CERTAIN CIRCUMSTANCES, YOUR REQUEST MAY BE DENIED.*

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU SHOULD CALL THIS MATTER TO THE ATTENTION OF OUR PRIVACY OFFICER IN WRITING.

John J. Moran, D.M.D.
Zachary S. Zemla, D.M.D.
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ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS DENTAL PRACTICE'S HIPPA NOTICE OF PRIVACY PRACTICES.

____
PATIENT NAME(PLEASE PRINT)

______________________________ ______________________________
PATIENT SIGNATURE *DATE*

OR

____
SGNATURE OF PERSONAL REPRESENTATIVE

AUTHORITY OF PERSONAL REPRESENTATIVE TO SIGN FOR PATIENT(CHECK ONE):

PARENT_____ GUARDIAN_____ POWER OF ATTORNEY_____ OTHER_____

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

DENTAL OFFICE USE ONLY

I TRIED TO OBTAIN WRITTEN ACKNOWLEDGEMENT BY THE INDIVIDUAL NOTED BOVE OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT IT COULD NOT BE OBTAINED BECAUSE:

_____ *AN EMERGENCY PREVENTED US FROM OBTAINING ACKNOWLEDEGEMENT.*

_____ *A COMMUNICATION BARRIER PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT.*

_____ *THE INDIVIDUAL WAS UNWILLING TO SIGN.*

_____ *OTHER*

____

______________________________ ______________________________
STAFF MEMBER SIGNATURE *DATE*