GALLERY OF SMILES

220 Ridgedale Avenue, Suite B1
Florham Park, NJ 07932
(973) 295-6700

Patient Information

Name: _____ Birth Date: _____ Social Security #: ___ ___ ___
Address: _____
Street City State Zip
Phone: (H) _____ (W) _____ (M) _____
Occupation: _____ Company: _____
Company Address: _____
Street City State Zip
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced Gender: ☐M ☐F

Spouse or Responsible Party Information

The party responsible for payment is: ☐Patient ☐Spouse ☐ Other: _____
Check if same as above ☐

Name: _____ Birth Date: _____ Social Security #: ___ ___ ___
Address: _____
Street City State Zip
Phone: (H) _____ (W) _____ (M) _____
Occupation: _____ Company: _____
Company Address: _____
Street City State Zip
Marital Status: ☐ Married ☐Single ☐ Separated ☐ Divorced

Insurance Information

Primary Insurance:
Name of Insured: _____ Social Security #: _____
First Middle Last
Patient's Relationship to Insured: ☐Self ☐ Spouse ☐ Child ☐ Other Birth Date: _____
Employer: _____
Name Street City State Zip
Insurance Carrier: _____ ID: _____ Group #: _____

Secondary Insurance:
Name of Insured: _____ Social Security #: _____
First Middle Last
Patient's Relationship to Insured: ☐Self ☐ Spouse ☐ Child ☐ Other Birth Date: _____
Employer: _____
Name Street City State Zip
Insurance Carrier: _____ ID: _____ Group #: _____

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Patient Name: _____ Date: _____

Who may we thank for referring you to our practice?

Name: _____ Address: _____

☐ Patient ☐ Friend ☐ Doctor ☐ Office ☐ Website ☐ School ☐ Ad: _____ ☐ **OTHER:** _____

Dental History

Is this your first trip to the dentist? ☐ YES ☐ NO

If NO, when was your last dental visit? _____

Reason for changing dentists: _____

Please tell us why you are here (*routine visit, emergency, other concerns*): _____

_____

Have you ever had any complications following dental treatment? ☐ YES ☐ NO

If YES, please explain: _____

Medical History

Are you now under the care of a physician? ☐ YES ☐ NO

Primary Care Physician: _____

Name Address Phone

Have you been admitted to a hospital or needed emergency care during the past 2 years? ☐ YES ☐ NO

If YES, please explain: _____

Do you currently take/use any prescription medication? ☐ YES ☐ NO

If YES, please specify name and dosage: _____

Do you have any allergies (*medication, food, seasonal, etc.*)? ☐ YES ☐ NO

If YES, please specify: _____

Have you ever been told that you have a heart murmur or other heart condition? ☐ YES ☐ NO

If YES, do you require antibiotic premedication before dental visit? ☐ YES ☐ NO

Please specify the heart condition: _____

Please check any previous or existing condition that applies to you:

☐ Anemia	☐ Fainting	☐ HIV/AIDS	☐ Stomach Problems
☐ Arthritis	☐ Glaucoma	☐ Liver Disease	☐ Stroke
☐ Artificial Joints	☐ Growths	☐ Mental Disorder	☐ Tuberculosis
☐ Asthma	☐ Hay Fever	☐ Nervous Disorder/Anxiety	☐ Ulcers
☐ Blood Disease/Disorder	☐ Head Injuries	☐ Pacemaker	☐ Venereal Disease
☐ Cancer/Tumor	☐ Heart Disease	☐ Pregnancy, Due: _____	☐ Codeine Allergy
☐ Diabetes	☐ Heart Murmur	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Dizziness	☐ Hepatitis	☐ Respiratory Problems	
☐ Endocrine Disorder	☐ High Blood Pressure	☐ Rheumatic Fever	☐ OTHER:
☐ Epilepsy	☐ Jaundice	☐ Rheumatism	_____
☐ Excessive Bleeding	☐ Kidney Disease	☐ Sinus Problems	_____

To the best of my knowledge, the information above pertaining to me is correct and accurate. I will promptly inform the doctors of any changes in my health.

Signature of Patient/Responsible Party: _____ Relationship: _____ Date: _____

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CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the reasonable time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of patient, parent or guardian

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of guarantor of payment/responsible party

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Authorization to Release Dental Information

I hereby authorize Gallery of Smiles or Gallery of Little Smiles to release any and all dental information to process my insurance claim.

_____ _____
Signature Date

Assignment of Benefits

I hereby assign all dental benefits to which I am entitled to Gallery of Smiles or Gallery of Little Smiles. I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to Gallery of Smiles or Gallery of Little Smiles. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Signature Date

Appointment Cancellation Policy

Your time, and the time of all other patients of the practice is important.

We take your appointment very seriously and try very hard to see each patient on time. We also make every effort to limit the length of your appointment to the time allocated so that you may make any other scheduled appointments that you may have later in the day.

In order to successfully respect your scheduling needs, we ask that you also respect the scheduling needs of others. We require a minimum 24 hours notice in order to reschedule your appointment.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be subject to a $50 charge per missed appointment.

Thank you for your understanding and cooperation.

By signing below, you acknowledge that you understand and agree to the above policy.

Signature: _____

Date: _____