Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Email:
_____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

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

OTHER:
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

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 1½% 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 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

Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Consent for Services and Treatment

I understand that my child is presenting in the office today for dental treatment. Treatment includes all services that Dr. Hernandez or Dr. Soyupak may deem necessary to the patient's health including diagnostic services such as exams and/or x-rays, and minimally invasive services such as SDF (Silver Diamine Fluoride), placement of resin modified glass ionomer, SMART technique, and HALL Crown. As his / her parent/guardian I agree to all treatment that the doctor may deem necessary for the patient's health, prior to and/or during treatment to be performed. I also acknowledge that treatment may be amended from what was previously planned due to changes that are found on the day of treatment, prior to or during treatment. **Please Initial here:** _____

In the case that the patient does not cooperate and treatment cannot be performed, patient/guardian agrees to pay the charge of **$120** for the time, effort and/or nitrous gas performed by the doctor. **Please initial here:** _____

Upon signing this document, the patient/guardian agrees to fully understanding and accepting the terms of agreement below:

- I understand that the full cost for treatment or copay based on private insurance coverage is expected on the day of service. **Please initial here:**_____
- I also understand that although the copay may be collected, it is only an estimate. **Please initial here:**_____
- If the full amount is not collected by the patient's insurance, patient/guardian is responsible for payment of the full balance. **Please initial here:**_____
- Payment can be made with cash, or a credit card charge. **Please Initial here:** _____

Should it become necessary for Bergen Pediatric Dentistry to pursue legal action or to use an outside agency to collect payment, I understand that I will be additionally responsible for any and all charges that Bergen Pediatric Dentistry incurs as a result of this action.

Parents of Minor Patients: The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Bergen Pediatric Dentistry will not be involved with separation or divorce disputes. **Please Initial here:** _____

Thank you for taking the time to review Bergen Pediatric Dentistry's policies. Please feel free to ask any questions or share with us special concerns.

By willingly signing below, I am agreeing that I have read and understand the above statements and I agree to the terms.

Patient's Name: _____ DOB: ____/____/____

Guarantor Print and Sign Name: _____Date: ____/____/____

Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Financial Agreement

I hereby authorize and guarantee payment for all services rendered.

1) **All** fees for services are **due** and payment expected at the time services are rendered. **Please initial here:** _____

2) For any **balance** remaining, I acknowledge that payment is due and expected at the time the billing statement is received. **Please initial here:**_____

3) I also acknowledge that although the copay may be collected, it is only an estimate. Any balance amount not paid by the patient's insurance, patient/guardian is responsible for payment of the full balance. **Please initial here:**_____

4) Any balance on account not paid will be submitted to a collection agency. **Please initial here:**_____

5) Parents of Minor Patients: The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Bergen Pediatric Dentistry will not be involved with separation or divorce disputes. **Please initial here:**_____

Thank you for taking the time to review Bergen Pediatric Dentistry's policies. Please feel free to ask any questions or share with us special concerns.

By willingly signing below, I am agreeing that I have read and understand the above statements and I agree to the terms.

Print Name: Responsible Party **Signature: Responsible Party**

_____

Date

BILL OF RIGHTS

- You have a right to choose your own dentist and schedule an appointment in a timely manner.
- You have a right to know the education and training of your dentist and the dental care team.
- You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
- You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
- You have a right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
- You have a right to an explanation of the purpose, probably (short and long term) results, alternatives and risks involved before consenting to a proposed treatment plan.
- You have a right to be informed of continuing health care needs.
- You have a right to know in advance the expected cost of treatment.
- You have a right to accept, defer or decline any part of your treatment recommendations.
- You have a right to reasonable arrangements for dental care and emergency treatment.
- You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.
- You have a right to expect the dental team members to use appropriate infection and sterilization controls.
- You have a right to inquire about the availability of processes to mediate disputes about your treatment.

(Adopted by the American Dental Association in 2009)

Your Responsibilities as a Patient

- You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
- You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.
- You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
- You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
- You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.
- You have the responsibility to keep your scheduled appointments.
- You have the responsibility to be available for treatment upon reasonable notice.
- You have the responsibility to adhere to regular home oral health care recommendations.
- You have the responsibility to assure that your financial obligations for health care received are fulfilled.

(Adopted by the American Dental Association in 2009)

You are confirming that you have read and understand your rights and responsibilities as a patient of this office.

_____

Print Patients Name

_____ **DATE :** _____

Parent/ Gaurdian's Signature

Bergen Pediatric Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: (Last, First)
Address: (Insert Address)
Telephone: (Insert Phone #) E-mail: (Insert Email Address)
Social Security #: (Insert Social Security #)

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Bergen Pediatric Dentistry 23-00 Route 208, Suite 2-5 Fair Lawn, NJ 07410 (201)796-4111

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE
I, (insert child's name), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.
HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

You May Refuse to Sign This Acknowledgement*

I, (insert child's name), have received acknowledgement of this office's Notice of Privacy Practices.

_____ June 9, 2023
Signature

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
☐☐ ____ Individual refused to sign
☐☐ ____ Communications barriers prohibited obtaining the acknowledgement
☐ ☐☐ ____ An emergency situation prevented us from obtaining acknowledgement
☐ ☐☐ ____ Other (Please Specify)
_____
_____
_____

Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Informed Consent

I, _____ give my consent for Dr. _____ to perform the following treatment/procedure _____ on (Patient's name) _____ previously explained to me or other procedures deemed necessary or advisable to complete treatment.

I understand that the purpose of the procedure/treatment is to treat and possibly correct the diseased oral/maxillary tissues. The benefits derived from this procedure/treatment as well as the alternative to NO treatment have been explained to me.

I have been informed and understand that there are inherent risks and/or complications of the treatment, drugs and or anesthesia, including: **pain, swelling, discoloration, bleeding, infection, numbness, tingling, or stiffness** of the jaw muscles; referral pain to adjacent structures such as the ear or cheek; temporomandibular joint (TMJ) difficulty, possibility of **small root fragments remaining in the jaw,** when their removal would require extensive surgery, and finally **damage to adjacent structures** such as teeth, fillings, crowns and/or gums. Complications might include **nausea or vomiting, allergic reaction, bruises, delayed healing, sinus involvement** requiring a secondary surgical procedure, and/or **devitalization** of adjacent teeth requiring root canal.

Women, the effectiveness of birth control pills may be interfered with the use of antibiotics and other medications.

Certain possible risks exist that although uncommon, could include nausea, pain, swelling, inflammation and/or bruising at the injection site. Rare complications include allergic or unexpected drug reactions, pneumonia, heart attack, stroke, brain damage, and/or death. Medications, drugs, anesthetics or prescription medications may cause drowsiness and lack of coordination, which is made worse with consumption of alcohol or other drugs.

I consent to the performances of the treatment and procedures in addition to, or different from those not contemplated, whether arising from presently unforeseen conditions which the above named doctor, and his/her associate or assistant, may consider necessary or advisable in the course of treatment.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO THE TREATMENT, ALL STATEMENTS MADE THEREIN ARE TRUE, AND ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE PROPERLY COMPLETED BEFORE I SIGNED.

_____ _____

(PATIENT/GUARDIAN SIGNATURE) (DATE)

When a patient is under18 years of age (with the exception of emancipated minors) or is incompetent to give consent. I hereby certify that I have explained to the patient/relative or guardian in plain language the nature, purpose, benefits, risks of, and alternative to the proposed procedure/treatment, have offered to answer any questions and have fully answered any questions and have fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physician:_____

(Signature) (Print) (Date)