Riverside Dental Health

Financial Policy

Patient Data

Name_____ Sex _____ SS#_____

PERSON FINANCIALLY RESPONSIBLE:_____

ADDRESS OF PERSON FINANCIALLY RESPONSIBLE:_____

_____

1. INSURANCE. We participate in most insurance plans. If you are not insured by a plan we do business with, payment is expected in full at each visit. If you are insured with a plan that we are contracted with, but do not have an up to date insurance card, payment in full at each visit will be required until we can verify your coverage. Knowing your insurance benefits is YOUR responsibility. Please contact the insurance company with any questions you may have regarding your coverage.
2. CO-PAYMENTS AND DEDUCTIBLES. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on the part of patients can be considered fraud. Please help us to uphold the law by paying your copayment at the time of service.
3. NON COVERED SERVICES. Please be aware that some- and perhaps all- of the services you receive may be non- covered or not considered reasonable or necessary to insurers. You must pay for these services in full at the time of visit. We will adhere to the insurance fee schedule if applicable.
4. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the Doctor. We must obtain a copy of your driver's license and current valid insurance in order to verify proof of insurance. If you fail to provide us with the correct insurance in a timely manner, you will be responsible for the balance of the claim.
5. CLAIM SUBMISSION. We will submit your claims and assist in any way reasonable to obtain payment of your claims. Your insurance company may need for you to provide information directly. It is your responsibility to comply in a timely manner with their request. Please be advised that the balance of the claim is your responsibility whether or not the insurance pays your claim. Your insurance policy is a contract between you and your insurance company. We are not party to that contract.
6. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you to obtain the maximum benefit. If your insurance company does not pay the claim in 45 days then the balance will automatically be billed to you.
7. NON-PAYMENT. If your account is over 90 days past due, you will receive a letter that you have 20 days to pay the full balance due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. A surcharge of 25%-40% will be added to any account turned over to a collection agency. A $50.00 returned check fee will apply to your account for any checks returned from your financial institution.
8. MISSED APPOINTMENTS. We may charge for appointments missed or cancelled with less than 24 hours notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policies of Riverside Dental Health and agree to abide by its guideline.

Signature of Patient:_____ Date:_____

Witnessed by:_____ Date:_____

Riverside
DENTAL HEALTH
Gary Esoldi, D.M.D.

CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Riverside Dental Health is to provide quality dental care in a timely manner. No shows and late cancellations inconvenience those individuals who need access to timely or emergency care.

We ask that you please call our office a minimum of **24 hours** in advance to cancel or to reschedule an appointment so that we can better utilize available appointments for our patient's in need of care.

A $25.00 fee will be billed to your account for late cancellation or "no shows".

_____ _____

Signature **Date**

481 Hackensack Avenue
Hackensack, NJ 07601
www.riversidedentalhealth.com
info@riversidedentalhealth.com
(201) 488-8228
(201) 488-4155

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Gary Esoldi, D.M.D.

Patient Name_____ Date_____

Please advise if you are taking any of the following:

Fosamax: Y / N

Actonel: Y / N

Boniva: Y / N

Dodronel: Y / N

Skelid: Y / N

Areda: Y / N

Zometa: Y / N

Gary Esoldi, D.M.D.

Notice of Privacy Practices

Riverside Dental Health complies with the Health Insurance Portability and Accountability Act of 1996 and the Department of Health and Human Services rule that are designed to preserve the privacy of identifiable patient information.

By singing below I acknowledge that I have been made aware that Riverside Dental Health has a **HIPAA** policy in effect and I understand that a copy of the policy will be made available to me at my request.

Patient Name (print) Date

Patient Signature Date