Dr. Gashinsky, D.D.S. **91 Milburn Ave** **Millburn, NJ 07041**
Telephone: 973.379.9080 **Facsimile: 973.376.6221** **Email: drg@drgdds.com**

Patient Information

Date:_____

Patients Name First_____Last_____

Home Address:_____City:_____Zip Code:_____

Home Phone:_____Work Phone: _____

Cell Phone:_____E-Mail: _____

Marital Status (circle one): Single☐Married☐Divorced☐Widowed☐Separated☑

Date of Birth: _____Social Security #: _____

Driver's License/State ID #: _____

Employer: _____

Employer's Address: _____

Spouse or Parent's Name: _____

Spouse/Parent's Employer: _____

Spouse/Parent's Employer Address: _____

Spouse/Parent's Work Phone: _____

Whom shall we contact in case of emergency? _____

Phone number they can be reached at: _____

Whom may we thank for referring you? _____

A Note to Our Patients:

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please don't hesitate to call

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Dental History

Reason for today's visit: _____

Former Dentist: _____

Address: _____

Date of last dental visit:_____Date of last dental x-rays: _____

Check the box if you have any of the following:

❑Bad breath
❑Bleeding gums
❑Clicking or popping jaw
❑Food collection between teeth
❑Grinding teeth
❑Loose teeth or broken fillings
❑Periodontal treatment
❑Snoring
❑Sensitivity to heat or cold
❑Sensitivity to Sweets
❑Sensitivity when biting
❑Sores or growths in your mouth

How often do you floss?_____How often do you brush? _____

Are you happy with the appearance of your smile? ☐ Yes No ☐

Do you wish your teeth could be whiter ? ☐ Yes No ☐

Medical History

Physician's name:_____Date of last visit: _____

Have you had any serious illness or operations? Yes No If Yes, Describe: _____

Have you ever had a blood transfusion? Yes No If Yes, give approximate dates:_____

Do you have a tobacco habit? Yes No If Yes, how much daily? _____

(*Women Only*) Are you pregnant? ☐ Yes No ☐

Nursing? ☐ Yes No ☐

Taking birth control pills? ☐ Yes No ☐

Check the box if you have any of the following:

❑AIDS
❑Anemia
❑Arthritis, Rheumatism
❑Artificial Heart Valves
❑Artificial Joints
❑Asthma
❑Back Problems
❑Blood Disease
❑Cancer
❑Chem. Dependency
❑Chemotherapy
❑Circulatory Problems
❑Cortisone Treatments
❑Cough, Persistent
❑Cough up Blood
❑Diabetes
❑Epilepsy
❑Fainting
❑Glaucoma
❑Headaches
❑Heart Murmur
❑Hemophilia
❑Heart Problems
❑Describe
❑Hepatitis
❑High Blood Pressure
❑HIV Positive
❑Jaw Pain
❑Kidney Disease
❑Liver Disease
❑Mitral Valve Prolapse
❑Nervous Problems
❑Pacemaker
❑Psychiatric Care
❑Radiation Treatment
❑Respiratory Disease
❑Rheumatic Fever
❑Scarlet Fever
❑Shortness of Breath
❑Sleep Apnea
❑Stroke
❑Swelling of feet/ankles
❑Thyroid Problems
❑Bisphosphonates(fosamax) oral_____or IV_____
❑Tonsillitis
❑Tuberculosis
❑Ulcer
❑Venereal Disease

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Medications/Allergies

List any known allergies/allergic reactions:

_____
_____
_____
_____

List any medications AND/OR supplements you are currently taking:

_____
_____
_____
_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature:_____ Date: _____

(If patient is a minor, parent/guardian should sign)

Payment is due in full at time of treatment unless prior arrangements have been approved.

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Financial Options

Our commitment is to provide quality dental care for the entire family through our exceptional service and application of advanced technology.

Methods of Payment (No Checks Accepted)

1. Cash or Credit Card (Visa, MasterCard, American Express, and Discover)
2. Care Credit or Dental Fee Plans (3rd Party)
3. Debit or Check Card

Dental Insurance (If Applicable)

1. We are pleased you have dental insurance and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company.
2. As a courtesy to you, we will file your insurance if we are able and we will accept assignment of benefits. We ask that your estimated co-payment and deductible be paid at the time of service.
3. Not all services are a covered benefit in all contracts. Some companies arbitrarily select certain services they will not cover.
4. For any major work (Bridges, Crowns, Partials, Dentures, etc.) most insurance companies do not require a pre-determination. However, as a courtesy to our patients, we submit pre-determinations so that the patient is aware of the amount the insurance will pay. This process takes 4-6 weeks. If the work needs to be done right away, we will ask you to take care of the payment in full and the insurance company will reimburse you directly.

I have read and understood the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered.

Name (please print): _____

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature:_____Date: _____

For Office Use Only

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 acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

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Cancellations and Missed Appointments Policy

When you schedule an appointment in our office, that time is reserved especially for you. When you miss an appointment, without calling to cancel within a reasonable period of time, your practitioner does not have the opportunity to offer that time to someone else in need of services. Missed appointments also interfere with your progress in treatment.

It is our policy that patients are responsible for all appointments they have scheduled. Patients who choose not to attend or call to cancel their appointment are still responsible for these appointments time. Therefore, the following policy will apply:

24 HOURS (1 WORKING DAY) NOTICE IS REQUIRED TO CANCEL EACH ONE HOUR APPOINTMENT YOU HAVE SCHEDULED. (Example: 1 hour or 45min scheduled =1working days notice 2 hours scheduled = 2 working days notice, 3 hours scheduled = 3 working days notice etc)

Fees for missed appointments and or late cancelations are expected at or before the patient's next scheduled appointment. Insurance does not cover these fees.

Any patient who misses more than two appointments without sufficient notice of cancellation during his or her course of treatment is subject to review and may be required to prepay for scheduled sessions.

**Any exceptional circumstances will be submitted to our Office Manager for review.*

Patient or Guardian Signature_____Date _____