



159 Delaware St  
Woodbury, N.J. 08096  
856-848-8400

**Vanaria Dental**  
Michael Vanaria, D.M.D.

1630 Riverton Rd.  
Cinnaminson, N.J. 08077  
856-786-2020

# WELCOME

**1**

## ABOUT YOU

Today's Date: \_\_\_/\_\_\_/\_\_\_

**Patient Name:** \_\_\_\_\_

LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Mobile Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many: \_\_\_\_\_

**2**

## INSURANCE INFO

### Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Insured's Employer: \_\_\_\_\_

### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Insured's Employer: \_\_\_\_\_

**3**

## ACCOUNT INFO

### Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

**4**

## IN EVENT OF EMERGENCY

Who should we contact?: \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone#: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

# 5

## DENTAL INFORMATION

Reason for today's visit: \_\_\_\_\_

Are you in pain?  No  Yes  How long? \_\_\_\_\_

Please indicate  any of the following problems:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw. | <input type="checkbox"/> Lost/Broken Fillings | <input type="checkbox"/> Stained teeth                         | <input type="checkbox"/> Broken/Chipped tooth |
| <input type="checkbox"/> Red, swollen or bleeding gums           | <input type="checkbox"/> Teeth grinding       | <input type="checkbox"/> Locking Jaw                           | <input type="checkbox"/> Bad breath           |
| <input type="checkbox"/> Sensitive tooth, teeth or gums          | <input type="checkbox"/> Ringing in Ears      | <input type="checkbox"/> Blisters/Sores in or around the mouth |   |
| <input type="checkbox"/> Other: _____                            |   |  |   |

Do you require the use of antibiotics prior to dental visit?  Yes  No  Don't know

Previous Dentist: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Phone Number

Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use?  Soft  Medium  Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

# 6

## MEDICAL HISTORY

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Heart Attack/Stroke     | <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Cancer/Tumors              | <input type="checkbox"/> Cosmetic Surgery      |
| <input type="checkbox"/> Heart Surg./Pacemaker   | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Shingles                   | <input type="checkbox"/> Radiation Treatment   |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Liver Problems          | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Chemotherapy          |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Respiratory Problems    | <input type="checkbox"/> HIV+/AIDS/ARC              | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Arthritis/Rheumatism       | <input type="checkbox"/> Difficulty Breathing  |
| <input type="checkbox"/> Artificial Valves       | <input type="checkbox"/> Stomach Problems/Ulcers | <input type="checkbox"/> Artificial Bones/Joints    | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Leukemia              |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Venereal Disease        | <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Chest Pains             | <input type="checkbox"/> Alcohol/Drug Abuse      | <input type="checkbox"/> Severe/Frequent Headaches  | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Tuberculosis TB         | <input type="checkbox"/> Frequent Neck Pain         | <input type="checkbox"/> Low Blood Pressure    |
| <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Jaw Problems TMJ/TMD    | <input type="checkbox"/> Back Problems              | <input type="checkbox"/> Bleeding Problems     |
| <input type="checkbox"/> Autism                  | <input type="checkbox"/> ADHD                    | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Glaucoma              |

Please list any other medical condition(s) you have or ever had: \_\_\_\_\_

Please list all medications you are taking: \_\_\_\_\_

Pharmacy Name and Phone# \_\_\_\_\_

Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin  
 Dental Anesthetics  Others: \_\_\_\_\_

Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses?  Yes  No

Have you ever taken the drug Phen-fen and or Redux?  Yes  No How many children have **you** had?

Are you pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for the legal fees collection agency fees, interest charges any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provide.
- I understand this office requires a 24 hour cancellation notice. If I do not cancel prior to the 24 hour, I may incur a \$50.00 charge

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- Adult Patient  Parent or Guardian  Spouse

**UPDATE  
(OFFICE USE)**

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Initials Date

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Initials Date

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Initials Date

# Office Policy

Please read and sign at the bottom, acknowledging that you were informed of these policies. Thank you.

## Financial Policy

Thank you for choosing **Dr. Michael Vanaria** to service your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

→ Before or on your first visit we expect you to supply our office with your insurance information. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

→ Patients are required to pay their deductible and co-payments at the time of each visit.

→ While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.

→ As a courtesy, we will gladly bill your insurance when you provide us with the information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you pay your portion of the bill at the time of service. Insurance policies are a contract between you, your employer, and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.

→ If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that "This will be the final notice for payment". If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

→ As a patient without insurance, you are always responsible for any charges at the time of service.

## Failed or Cancelled Appointments

We confirm all appointments the day before your scheduled time. Please be aware that a missed appointment hurts 3 people; you, the doctor, or hygienist, and the person who could have used the time. A cancellation charge will be made for broken appointments unless 24 hours notice is given to cancel or change same. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

## Estimates and Fees

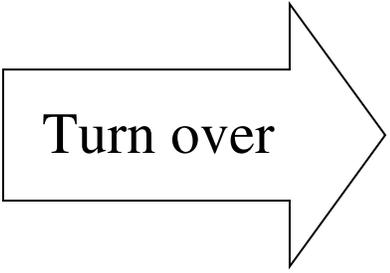
After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered.

## Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency. The patient will be responsible for a 35% collection fee.

## Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. 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. We encourage you to read it carefully and completely before signing this Consent.



Turn over

# Authorization for Signature on File

Release of Information/ Financial Responsibility/ Authorization for Payment

I (name of patient) \_\_\_\_\_ and/or (name of insured) \_\_\_\_\_

Hereby authorize **Dr. Michael Vanaria** to affix my name to any and all claims or documents as related to any and all dental benefits for me and my dependents. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to the claim. If dental insurance does not apply to me, I am financially responsible for charges at the time of service.

By signing below I am agreeing that I have read the office policy and Notice of Privacy Practice.

Signature of Patient (parent or guardian if minor): \_\_\_\_\_

Today's Date: \_\_\_\_\_

A photocopy of this document may act as an original.

## Referrals Are Important To US

Whom may we thank for referring you to our office?

- Family/Friend \_\_\_\_\_
- Dental Insurance Website
- Internet/Google search
- Facebook
- Newspaper Mailing
- Other \_\_\_\_\_

## Financial Consent

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within **30** days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance and any changes thereto.

All returned checks will be subject to a **\$50.00** returned check fee. Any account balances that remain unpaid for **121** days from the date of service may be referred to an attorney. In the event this occurs, I understand that I will be liable for collection costs (**35%**) that may be imposed from the attorney who acquires my account. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid balance has been assigned or referred by mail at any address that I provide to the dental office an/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Parent/Guardian Signature, if minor: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Vanaria Dental**