HoHoKusDental
ASSOCIATES

WELCOME

You have recently made an appointment with HoHoKus Dental Associates. Please take a few minutes to complete the attached forms and bring them with you at the time of your visit. This will enable our office to be more efficient and help us to remain on schedule. Our office is located at 625 North Maple Ave, Ho-Ho-Kus, NJ, on the corner of Maple and Franklin Turnpike (next to the brook). All our patients are seen on an appointment basis. If you are unable to keep your appointment for any reason, please give us at least **48 hour notice**. This courtesy will allow us to be of service to other patients. Our phone number is (201) 670-9076.

If you are being referred by another patient, please include this information on the enclosed Patient Registration Form (section 3). You will receive a $50 credit from our referral program, as will the patient who referred you.

We hope you find our office and staff pleasant, friendly, and efficient. If you have any questions regarding insurance or the attached forms, please call our office before your visit.

Thank you in advance for your cooperation.

Name _____

Appointment Date _____

Time _____

Dentist/Hygienist _____

Please Arrive 15 Minutes Prior To Scheduled Appointment

HoHoKusDental
ASSOCIATES

PATIENT REGISTRATION

First Name: _____ **Last Name:**_____

Patient is: □ Policy Holder □ Responsible Party

Patient Information

Address:_____

City: _____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Birth Date:_____ Age:_____ SSN:_____

Email:_____ □ I would like to receive correspondences via e-mail

Referred by: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Responsible Party (if someone other than the patient)

Address:_____

City:_____ State: _____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □Widowed

Birth Date:_____ Age:_____ SSN:_____

□ Responsible Party is also a Policy Holder for Patient □ Primary Insurance Policy Holder □ Secondary insurance holder

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: □Self □Spouse □Child □Other

Insured Birth Date: _____

Insured SSN: _____

Employer:_____

Address:_____

City/State/Zip:_____

Insurance Company:_____

Address:_____

City/State/Zip:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: □Self □Spouse □Child □Other

Insured Birth Date: _____

Insured SSN: _____

Employer:_____

Address:_____

City/State/Zip:_____

Insurance Company:_____

Address:_____

City/State/Zip:_____

HoHoKusDental
ASSOCIATES

HoHoKus Dental Associates 'HIPAA' Notice of Privacy Practices

Michael T. Varallo, D.M.D. ▪ Joseph E. Mauriello, D.D.S. ▪ Marissa Sala D.D.S.

Patient name _____

Patient address _____

Patient phone number _____ **Patient email** _____

We understand that your health information is personal and we are committed to protecting it. This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. You have the right for access and review of your health information and you have the right to restrict use and disclosure. By reviewing and signing, you authorize the professional office of the dentist named above to use or disclose health information identifying you under the following terms and conditions:

- **Treatment and Health Care Operations**
  - We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care. Disclosure also includes operations necessary to run our practice, including daily staff review of your treatment and services, training, and business planning and development.
- **Payment**
  - We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
- **Appointment Reminders**
  - We may use or disclose your health information when reminding you of a dental appointment by using a letter, phone call, voice message, text or email.
- **Disclosure To You as a Patient, Family, and Business Associates**
  - We may use and disclose your health information to tell you about treatment options or health-related services that may be of interest to you. We may disclose to a family member or friend who is involved with your care or payment for your care. We may disclose to our third-party service providers that perform functions on our behalf or provide us with services. (All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information.)
- **Less Common Uses and Disclosures**
  - Less common uses allowing us to disclose your health information include: disclosures required by law (U.S. Department of Health and Human Services, threat to health/safety), public health activities (reporting disability, injury, disease, or death), lawsuits, law enforcement, and legal action. Certain laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related, alcohol and substance abuse, mental health information, and genetic information. If applied to you, contact us about your protection.

I have read and understand this form. I authorize the disclosure of my health information as described in this form.

Patient Signature_____ Date _____

**If you are signing as a personal representative of the patient, describe your relationship to the patient and sign.

Print Name and **Relationship** to Patient _____

Signature of Representative_____ Date _____

 ● 625 North Maple Ave, Ho-Ho-Kus, NJ 07423 ● Phone: 201-670-9076

HoHoKusDental
ASSOCIATES

HDA Medical/Dental History Update

Research has shown that periodontal disease is associated with several other diseases. For a long time it was thought that bacteria was the factor that linked periodontal disease to other disease in the body; however, more recent research demonstrates that inflammation may be responsible for the association. Therefore, treating inflammation may not only help manage periodontal diseases but may also help with the management of other chronic inflammatory conditions.

Medical History Update

Personal Health Questionnaire

□ Do you frequently experience headaches? Y / N
□ Do you have sleep apnea? Y / N
□ Do you snore loudly or have been told that you snore? Y / N
□ Do you ever awaken with a sensation of gasping or choking? Y / N
□ Do you often feel tired, fatigued, or sleepy during day time? Y / N

Dental History Update

Oral Health Questionnaire

□ What prompted you to seek dental care at this time? _____
□ Do you have sensitive teeth? Y / N
□ Do you have bad breath? Y / N
□ Do you have any loose teeth? Y / N
□ Do you have any chipped/worn teeth? Y / N
□ Do you have any discolored teeth? Y / N
□ Do you have dry mouth? Y / N
□ Are you satisfied with the way your teeth look (i.e. color, shape, alignment)? Y / N
□ Do you grind or clench your teeth? Y / N
□ Do you have a history of jaw joint (TMJ) disorder? Y / N
□ Do you have clicking, popping, or discomfort in your jaw joints? Y / N
□ How often do you brush? _____
□ How often do you floss? _____

Family History Update

Select all that apply

□ Gum Disease/Lost Teeth
□ Stroke
□ Insulin Resistance
□ Obstructive Sleep Apnea
□ Cardiovascular Disease
□ Other _____
□ Heart Attacks
□ Diabetes
□ Thyroid Disease
□ Alzheimer's Disease/Dementia
□ Cancer(s) _____
□ Joint Replacement
□ Obesity
□ Rheumatoid Arthritis
□ Low-Weight, Premature Birth
□ Organ Replacement

Medications

Select all that apply

□ Bisphosphonates (Osteoporosis medication)
□ Thyroid medication
□ Coumadin/blood thinners
□ Antidepressants
□ Anti-anxiety medication
□ Blood Pressure medication
□ Cholesterol Medication
□ Please list all medications:

_____

_____

***To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Patient Signature: _____ **Date:** _____

HoHoKusDental
ASSOCIATES

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care, and your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees and policies.

A. If you are an individual/family without insurance, payment in full is always required at time of service.

B. **If you have dental insurance,** it is your responsibility to know and provide us with your plan's requirements in advance, each and every time we provide service. Please be advised that if we have not been provided with your program's requirements, and if we provide any dental or laboratory service, you will be responsible for the fees up front at the time of service. ***Also, please note that insurance is never a guarantee of payment, and estimates given in office on what insurance might pay are not definite.

We will do our best to comply with your insurance company's requirements. Patients must inform us of changes in information or insurance plans prior to seeing the dentist or hygienist. If not, this may result in unprocessed insurance claims and finance charges accruing on your account. In order to process all claims, please provide us with a copy (front and back) of the following:

- Primary dental insurance card
- Secondary dental insurance card (*if applicable*)
- Medical insurance card (*if applicable*)

a. **Participating Plans** (Delta Dental Premier, Cigna PPO, and United Concordia Elite): Patients with participating plans must pay estimated portion of fee at time of service. In order to be billed for your portion after insurance pays, please see the **"*Credit Card Authorization and Consent Form*"**. By providing us access to your credit card information, it will eliminate any chance of automatic finance charges being placed on your account. If you choose not to provide access, please refer to Section C.

b. **Out Of Network Services**: Payment **in full** is expected at time of service, and you will be directly reimbursed by insurance once they process the claim.

C. If you or your family are with or without insurance and a balance exists on your account, you will receive a statement sent out by our billing department at the end of each month. Each month that your balance is not paid in full, a finance/interest charge will be added to your account in the amount of 2.0%. If this matter is referred to collection, a collection fee of 20% of the balance owed will be added. Once taken to collection, finance charges cannot be removed.

***I have read and understand the office policies stated above and agree to accept responsibility as described above.

Print Name _____

Signature _____ Date _____

HoHoKusDental
ASSOCIATES

CREDIT CARD AUTHORIZATION AND CONSENT FORM

Disclaimer: As a convenience and to avoid automatic finance charges, your credit card will be kept on file for billing after insurance compensates us. Additionally, please see our *"Office Financial Policy"* for information on our cancellation policy.

☐ Yes, I Give Permission To Have My Credit Card On File

I, _____ hereby authorize

HoHoKus Dental Associates to charge my credit card for dental services that are provided in office. By signing this consent form, I am allowing HoHoKus Dental Associates to charge my card in any case that I may have a balance on my account.

Type of Card* : ☐ Visa/MasterCard ☐ Amex ☐ Discover

☐ Flex Spending (FSA or HSA) ☐ Care Credit

Name of Cardholder*: _____

Credit Card Number*: _____

Expiration Date*: _____

CVC Code** (3 numbers): _____

Usage* (check one)**:**

☐ Can Use It When I Am Not Present

☐ Can Use It When I Am Not Present, **BUT** I Would Like A Phone Call or E-mail To Confirm

(***If there is no confirmation made, the card will not be charged)**

By signing this, I assume full responsibility for charges made on my card, and agree to honor and abide by the terms of payment. I acknowledge and accept that HoHoKus Dental Associates will have my credit card information on file, and it will only be used to charge in-office services.

_____

Patient Signature **Date**