Patient Information

Patient Name: ______________________________ Date: ___________
Last, First MI (Preferred Name)

Gender: __________ Birth Date: __________________________

Phone (Home): ______________________ (Cell): ______________________

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
- ☐ Asthma
- ☐ Autism
- ☐ 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
- ☐ 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:______________________________

Responsible Party Information

Father

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________________ (Cell): ____________________

Address: ____

____

Mother

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________________ (Cell): ____________________

Address: ____

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Insurance Information

Primary

Name of Insured: ____________________ Insured's Birth Date: ____________
Last First

Social Security #____________ ID #: ____________ Group #:____________

Street City State Zip Code

Insured's Employer Name: ____

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____________________ Insured's Birth Date: ____________
Last First

Social Security #____________ ID #: ____________ Group #:____________

Street City State Zip Code

Insured's Employer Name: ____

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.

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.

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

Dr. Elizabeth M. Merkler, DMD
2640 Route 70 Suite 2C
Manasquan, NJ 08736
(732) 223-2919

If you have any Dental Insurance, we will submit your claims to them for payment as a courtesy. However, in order for our billing department to do this, you must provide us with all of your insurance information, and a copy of your insurance card at the time of your visit. **You must notify us immediately if there are any changes to your insurance plan, or a new plan is in effect.**

If we can estimate how much of your bill is not going to be covered by your insurance company such as co-pays, deductibles, or your percentage of the visit, you will be required to pay this amount at the time of visit.

PLEASE NOTE: WE CAN ONLY ESTIMATE THE AMOUNT YOUR INSURANCE CARRIER MAY PAY TOWARDS THE SERVICES RENDERED. FINAL DETERMINATION WILL BE MADE BY THE INSURANCE COMPANY. YOU WILL BE BILLED FOR THE REMAINING BALANCE AFTER ALL INSURANCE PAYMENTS.

We strongly recommend that you also call your insurance company to check your benefits and we will assist you with any further questions.

Parent/ Guardian Signature: ________________________ Date :__________

DR. ELIZABETH MERKLER, DMD

2640 Route 70 Suite 2C
Manasquan, NJ 08736
732-223-2919

□ PATIENTS OUT OF NETWORK:

Coverage for services rendered by a non-preferred provider is limited to a maximum of the plan's payment.
The member is responsible for the difference between the billed charges and the plan payment.

□ FLUORIDE:

Our office recommends that children receive fluoride treatments every 6 months. Depending on your individual insurance plan, they may only cover the fluoride treatment 1 time a year. The second time the fluoride is done will be your financial responsibility.
It is your responsibility to inform the office if you only want the fluoride done once a year.

□ WHITE FILLINGS:

Please be advised Dr. Elizabeth Merkler only does resin (white) fillings. Some insurance plans will not pay for white resin filling. They provide benefits for amalgam restoration (silver).
Patients will be responsible for any difference between the fee the insurance pays for the amalgam (silver) filling, and the cost of the resin (white) filling.

□ LATE PAYMENTS:

All Balances left unpaid for over 90 days will incur a $50.00 late fee.

I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payments of benefits.

Patient Name:________________________________ Date:______________

Parent / Guardian Signature:____

<u>Hipaa Notice of Privacy Practices</u>

Dr. Elizabeth Merkler, DMD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health or condition and related health care services.

<u>1. Uses and Disclosures of Protected Health Information</u>

Uses and Disclosures of Protected Health Information

Your protected health information may be used to disclosed by your physician, our office and others outside of office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

<u>Treatment</u>: We will use and disclose your protected health information to provide, coordinate, or manage your health care with a third party. For example; we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have referred to ensure that the physician has the necessary information to diagnose or treat you.

<u>Payment</u>: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

<u>Healthcare Operations</u>: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign- in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health oversight: abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of the Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

<u>Your Rights</u>

Following us a statement of your rights with respect to your protected health information.

<u>Your have the right to inspect and copy your protected health information</u>. Under federal law, However your may inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of your civil, criminal, or administration action or proceeding, and protected health information this is subject to law that protect access to protected health information.

<u>You have the right to request a restriction of your protected health information</u>. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment; payment or healthcare operations. You may also request that any part of your protect health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state a specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted and you have the right to use another Healthcare Professional.

<u>You have the right to request to receive confidential communications from use by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us</u> upon request, even if you have agreed to obtain this notice alternatively i.e. electronically.

<u>You may have the right to have your physician amend your protected health information</u>. If we deny your request of amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement we will provide you with a copy of such rebuttal.

<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

<u>Complaints</u>

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name:______________________ Signature:__________________ Date: ________