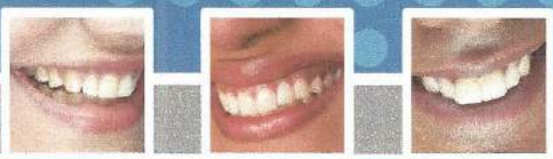
Mt. Arlington Family Dentistry
22 Howard Blvd., Suite 104
Mt. Arlington, NJ 07856

(973)770-3322
info@mtarlingtonfamilydentistry.com
www.mtarlingtonfamilydentistry.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

SOCIAL SECURITY #

Patient Name: Last | First | MI | Preferred Name

Title: (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Prev. Visit: Email Address:

Phone: Home | Work | Ext | Mobile Best time to call:

Address:

City | State | Zip Code

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet

☐ Newspaper ☐ School ☐ Work

☐ Other (name below):

Name of person, office, or other source referring you to our practice:

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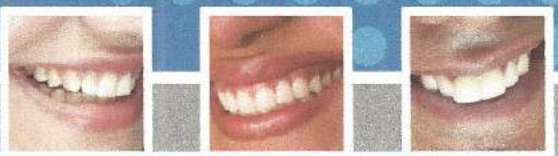

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

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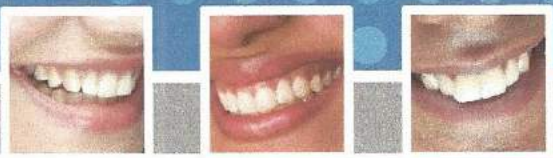

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ ____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ ____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ ____ _____
City State Zip Code

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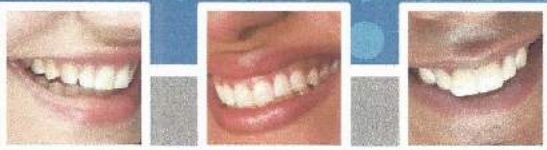

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

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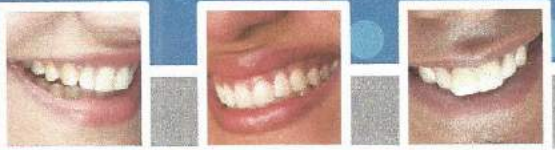

Medical History

Please check all that apply:

☐ *PREMED-Amox	☐ *PREMED-Clind	☐ *PREMED-Other	☐ Allergy Aspirin
☐ Allergy Codeine	☐ Allergy Erythro	☐ Allergy Hay Fever	☐ Allergy Latex
☐ Allergy Other	☐ Allergy Penicllin	☐ Allergy Sulfa	☐ Alzheimers
☐ Anemia	☐ Anxiety	☐ Arthritis	☐ ArtificialProsthesis
☐ Asthma	☐ Blood Disorder	☐ Blood Pressure High	☐ Blood Pressure Low
☐ Cancer	☐ Chemo Therapy	☐ Diabetes	☐ DO NOT RECLINE
☐ Emphysema	☐ Epilepsy	☐ Fainting	☐ Gagger
☐ Glaucoma	☐ Hearing Impairment	☐ Heart Disease	☐ Heart Murmur
☐ Heart MVP	☐ Hepatitis	☐ HIPAA SIGNED	☐ HIV+AIDS
☐ Kidney Disease	☐ Liver Disease	☐ Lupus	☐ Meds- Beta Blockers
☐ Meds- Blood Thinners	☐ Meds- Daily Aspirin	☐ Meds- Dilantin	☐ Meds-Herbal Supps
☐ Meds-Other SEE CHART	☐ Mentally Challenged	☐ NO EPI	☐ NO-SAIDS
☐ Pacemaker	☐ PhysicallyChallenged	☐ Psychiatric Conditon	☐ Radiation Treatment
☐ RespiratoryCondition	☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever
☐ SEE CHART	☐ Seizures	☐ Sinus Disorder	☐ Stomach Condition
☐ Stroke	☐ TB	☐ Thyroid Condition	☐ Ulcers

List of Medication currently taking

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

Mt. Arlington Family Dentistry

Emanuel Catania, DMD
Roger M. Casulli, DDS
Peter Serratelli, DDS

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(973) 770-3322
Fax: (973) 770-3772

Office Financial Policy

It is our goal at Mt. Arlington Family Dentistry to provide you with the finest dental care available at a cost that is both fair and reasonable. In order to achieve this goal, we need your cooperation. Please read this Office Financial Policy and sign & date below. Thank you.

- **Dental Insurance:** Your dental insurance is a contract between you and your dental insurance carrier. As a courtesy to our patients we agree to file your dental insurance claims, however we DO NOT assume responsibility to know the full benefits of your individual plan. **Your estimated out-of-pocket portion for all dental services will be due on the date services are rendered. If your insurance carrier pays you directly, then you would be responsible to pay in full at the time of service.** In the event your insurance company does not cover a dental service, then you would be responsible for that service.
- **Uninsured Patient:** If you do not have dental insurance this category applies to you. Payment is due in full for all treatments received on the date of service. Please be prepared to pay for services rendered before leaving the office.
- **Broken Appointment Fee:** If you cancel or reschedule an appointment with less than 24-hour's notice, then you will be charged a broken appointment fee of $50.00 per missed appointment.
- **Returned Check Fee:** A fee of $25.00 will be charged for checks returned from the bank for ANY reason. If we receive a returned check on your account, then any and all future services will be payable by credit card or cash.
- **Dependent Minors:** The responsibility for payment of services rendered to a dependent rests with the "Presenting Parent" *(parent seeking treatment for dependent minor)*. This also applies to a minor with divorced/separated parents.
- **Financial Arrangements:** Our office offers many financial arrangements to suit our patient's needs, both in office and third party financing through Care Credit (application and approval required) if needed please ask the front desk staff members to review these options with you.

Patient Name *(print)*: _____

Patient Signature: _____ **Date:** _____