

# REGISTRATION FORM

PATIENT REGISTRATION FOR: \_\_\_\_\_

Residence Address: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME  
STREET ADDRESS APT. #  
TOWN / CITY STATE ZIP CODE

Home Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Cellphone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Preferred time for appointments: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Other family members in practice: \_\_\_\_\_ Marital Status: S M D W  
Will you take calls at work? \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

If Minor, Name of Guardian: \_\_\_\_\_  
Address & Telephone: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Student Status: F/T P/T N/A School Name: \_\_\_\_\_ City: \_\_\_\_\_

Person Responsible for fee (If other than patient) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address (If different from above) \_\_\_\_\_

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employment Address: \_\_\_\_\_  
STREET ADDRESS APT. #  
TOWN / CITY STATE ZIP CODE

## EMERGENCY NOTIFICATION

Nearest relative not living with you - Name & Telephone \_\_\_\_\_

## PERMISSION TO TAKE PHOTOGRAPHS, SLIDES & VIDEOS

I, (print name) \_\_\_\_\_, hereby authorize Drs. Jay & Janice Cazes, and their office staff to take photographs, slides, images and/or videos of my face, jaws and teeth.

I understand that the photographs, slides, images and/or videos will be used for educational purposes in lectures, demonstrations, and professional publications.

I further understand that if the photographs, slides, images and/or videos are used in any publication or as part of a demonstration, reasonable attempts will be made to conceal my identity.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
If a Minor, Signature of Parent or Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

# MEDICAL - DENTAL HISTORY

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

**INSTRUCTIONS:** To receive treatment in this office you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office - to the best of your ability honest answers must be given. If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor. Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (Not Applicable) in the space provided. All questions must be answered. To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included in this form is "Permission To Release Information". You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION

Name & telephone # of your physician \_\_\_\_\_

Date of last visit to your doctor \_\_\_\_\_ Purpose of visit \_\_\_\_\_

**NOTE:** There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Some drugs and medications used in routine dental care that decrease the effectiveness of birth control medications. Information about your current use of drugs and medications is essential. There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

**Please list any medications you take (including birth control pills if applicable):**

Have you ever had an allergic reaction to medication? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

**Have You Ever Had Or Been Treated For (Check ALL that apply):**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Prosthetic Heart Valve           | <input type="checkbox"/> Low/High Blood Pressure   | <input type="checkbox"/> A major operation  | <input type="checkbox"/> Excessive bleeding/anemia/blood transfusion |
| <input type="checkbox"/> Rheumatic Heart Disease          | <input type="checkbox"/> Convulsions or seizures   | <input type="checkbox"/> fainting spells  | <input type="checkbox"/> A serious injury to your head or neck       |
| <input type="checkbox"/> Epilepsy                         | <input type="checkbox"/> Other neurological disease  | <input type="checkbox"/> arthritis or rheumatism                                    | <input type="checkbox"/> Persistent swollen glands in the neck       |
| <input type="checkbox"/> Thyroid problems                 | <input type="checkbox"/> Breathing problems  | <input type="checkbox"/> asthma or bronchitis                                       | <input type="checkbox"/> Tuberculosis                                |
| <input type="checkbox"/> Allergies or hayfever            | <input type="checkbox"/> Stomach or intestinal disease   | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Kidney problems or dialysis                 |
| <input type="checkbox"/> Hepatitis or jaundice            | <input type="checkbox"/> Problems with the immune system   | <input type="checkbox"/> Lyme disease   | <input type="checkbox"/> A venereal disease                          |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Tumors or growths   | <input type="checkbox"/> AIDS/HIV-positive  | <input type="checkbox"/> Any disability                              |
| <input type="checkbox"/> A stroke                         | <input type="checkbox"/> Chemotherapy  | <input type="checkbox"/> Have you lost weight recently or are you on a special diet |  |
| <input type="checkbox"/> Do you drink alcoholic beverages | <input type="checkbox"/> Have you consulted or been treated by a psychiatrist, psychologist or counselor |   |  |
| <input type="checkbox"/> Do you smoke                     | <input type="checkbox"/> Use chewing tobacco or snuff  | <b>For females:</b> <input type="checkbox"/> Are you pregnant                       | <input type="checkbox"/> Are you nursing                             |

Are there any other problems about your health of which you are aware? \_\_\_\_\_

## DENTAL HISTORY

**Chief Dental concern** (Reason for today's visit) \_\_\_\_\_

Date of your last dental visit \_\_\_\_\_ Reason for your last visit \_\_\_\_\_

Do you have any of your X-rays or dental records? \_\_\_\_\_

Do any of your teeth ache? \_\_\_\_\_ Which one(s) \_\_\_\_\_ Are any of your teeth sensitive to heat, cold, or pressure? \_\_\_\_\_

Do you brush your teeth? \_\_\_\_\_ How often? \_\_\_\_\_ Do you floss? \_\_\_\_\_ How often? \_\_\_\_\_

Do you use mouthwash? \_\_\_\_\_ Do you use any other oral care products? \_\_\_\_\_

Do your gums bleed on brushing or eating? \_\_\_\_\_ Are there any sores or growths in your mouth? \_\_\_\_\_

Does food catch between your teeth? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? \_\_\_\_\_

Do you grind your teeth, clench your jaws, have pain or soreness in your jaw muscles, or have pain or clicking in the jaw joint around your ear? \_\_\_\_\_

Are you wearing removable dental appliances? \_\_\_\_\_ If yes, age of appliance(s) and description \_\_\_\_\_

In respect to any previous dental treatment, have you ever fainted, had an allergic reaction, had abnormal bleeding or any other complications during or following dental treatment? \_\_\_\_\_

Do you have any other dental complaint? \_\_\_\_\_

**NOTE:** A change in your health status should be reported to the office at the earliest possible time. To the best of my knowledge, the foregoing questions have been accurately answered.

**Permission to release health information** I grant the right to the dentist to release health information obtained from me, and information about my treatment to third party payors, and/or other health practitioners.

Person completing the form: \_\_\_\_\_ Witness: \_\_\_\_\_

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

# Insurance Underpayment Form

As a service to our patients, we file your dental insurance claims when you receive treatment. In addition, in order to decrease your out of pocket expense at the time of treatment, we accept assignment of benefits from your insurance company. We try to accurately estimate what those benefits will be, but at times this isn't always possible. In accordance with our office policy of accepting our patients insurance as part of full payment:

1. If there is an overpayment by the insurance carrier, we will reimburse you as soon as possible.
2. If there is a balance due after we receive your insurance... **you authorize us to charge your credit card for the balance.**
3. If the insurance company mails payment directly to you or the insurance company has not paid within 90 days of submission... **you authorize us to charge your credit card for the balance.**

The Credit Card is a: VISA    MASTERCARD    DISCOVER    AMERICAN EXPRESS    CARE-CREDIT

Credit Card #: \_\_\_\_\_ Security Code: \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Billing Zip Code: \_\_\_\_\_

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

Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

This Authorization expires two years from the date listed above

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**Cazes Family Dentistry, LLC**  
**ACKNOWLEDGEMENT OF RECEIPT OF**  
**NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received or reviewed a copy of this office's  
{Please Print Name} Notice of Privacy Practices.

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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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 the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

# Notice Of Privacy Practices

**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/13/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general

condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for external marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). This includes but is not limited to reminders about premedication before treatment in our office.

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. Your request for records will be honored within 14 days of receipt at our office. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$25 for full mouth radiographs, \$1.00 for each page, \$30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Janice C. Cazes, DDS, FAGD \_\_\_\_\_

Telephone: (908) 852-1100 \_\_\_\_\_ Fax: (908) 852-2522 \_\_\_\_\_

E-mail: cazesdentl@aol.com \_\_\_\_\_

Address: 358 Naughtright Road, Long Valley, New Jersey 07853-3806 \_\_\_\_\_