358 NAUGHRIGHT ROAD * LONG VALLEY, NJ 07853-3806 * (908)852-1100
www.cazesfamilydentistry.com

Welcome to our practice! We are excited that you have chosen Cazes Family Dentistry, LLC to provide you with the quality dental care that you deserve and we're looking forward to your visit with us. Our goal is to create the best dental experience for you and your family resulting in a healthy smile now and for a lifetime.

In preparation for our first meeting, Please look over our website and our Facebook page "Cazes Family Dentistry, LLC" to get a more in depth view of our practice.

In order to ensure that your visit runs as smoothly and efficiently as possible, I have enclosed the forms necessary for your appointment. Please take the time to read and sign each form where indicated, and bring the completed, signed forms with you on the day of your visit.

We are dedicated to enhancing the quality of life, one smile at a time, and look forward to meeting you.

Should any questions arise prior to your appointment, please don't hesitate to contact me directly. I can be reached at 908/852-1100 Monday through Thursday from 8am to 5pm.

Warm regards from your Dental Team at Cazes Family Dentistry, LLC.

Diane DeMayo

Patient Coordinator

To Our Valued Patient,

We have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. We also have a personal, professional, and ethical responsibility to care for your health to the best of our ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent us from achieving our goal of optimum health for you. Therefore, the following policies must be agreed upon:

1. It is our practice's policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to correct the situation.

2. If you cannot keep an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. Failure to keep an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. There is a $75.00 fee for all no-show appointments or cancellations with less than 48 hours notice. This fee is not covered by insurance.

3. Timeliness is required. We will strive to see you on time and get you out on time unless there is an emergency. If you arrive more than 10 minutes late, we may have to reschedule your appointment.

4. Cleanliness and infection control are of the utmost importance. We disinfect each treatment room after every patient. This is another important reason we require timeliness of ourselves and you.

5. Insurance: Treatment recommendations are based on your health **not** on your insurance or lack thereof. Remember insurance companies are not concerned about your health or well being – we are. We will provide you with an **<u>estimate</u>** of benefits. Your benefits are a contract between you and your insurance company. We can not be responsible for what your insurance will or will not cover.

6. We expect payment in full, prior to or at the time treatment is provided. If you have insurance, as a courtesy, we will submit for payment, however any out of pocket expenses are due at or prior to the time of service. Ultimately, you are responsible for all expenses incurred in our office. We have several financial options available for all of our patients. Please speak to one of our experienced front desk staff if you have any questions.

7. Emergencies are handled as soon as possible. There is always an emergency number where the doctors can be reached.

8. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.

We greatly appreciate your cooperation.

Your partners in Health,

Dr. Janice Cazes, Dr. Jay Cazes, and our exceptional team of professionals

_________________________ _________________________

Patient Office

REGISTRATION FORM

PATIENT REGISTRATION FOR:____
FIRST NAME MIDDLE NAME LAST NAME

Residence Address: ____ __________
STREET ADDRESS APT. #

________________________________ _______ _______-_____
TOWN / CITY STATE ZIP CODE

Home Telephone: ( ) _____-_______ Work Telephone: ( ) _____-_______
Cell Phone: ( ) _____-_______ 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 IMAGES, RADIOGRAPHS & VIDEOS

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

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

I further understand that if the photographs, images, radiographs 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. They relate directly to the safe and effective treatment you are to receive in the office. If you are unsure of the question, 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. 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:* 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 other 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*)**:**

❑ Prosthetic Heart Valve ❑ Low/High Blood Pressure ❑A major operation❑ Excessive bleeding/anemia/blood transfusion
❑ Rheumatic Heart Disease ❑ Convulsions or seizures ❑ fainting spells ❑ A serious injury to your head or neck
❑ Epilepsy ❑ Other neurological disease ❑arthritis or rheumatism ❑ Persistent swollen glands in the neck
❑ Thyroid problems ❑Breathing problems ❑asthma or bronchitis ❑ Tuberculosis
❑ Allergies or hay fever ❑Stomach or intestinal disease ❑ Diabetes ❑ Kidney problems or dialysis
❑ Hepatitis or jaundice ❑ Problems with the immune system ❑ Lyme disease ❑ A venereal disease
❑Cancer ❑Tumors or growths ❑ AIDS/HIV-positive ❑ Any disability
❑ A stroke ❑ Chemotherapy ❑ Have you lost weight recently or are you on a special diet
❑ Do you drink alcoholic beverages ❑ Have you consulted or been treated by a psychiatrist, psychologist or counselor
❑Do you smoke ❑ Use chewing tobacco or snuff ❑ Have you had a skin rash or other reaction to metal jewelry

For females: ❑Are you pregnant ❑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 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 jaw, 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, has 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: ____/____/____

358 NAUGHRIGHT ROAD * LONG VALLEY, NJ 07853-3806 * (908)852-1100
www.cazesfamilydentistry.com

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 Notice of Privacy Practices.
{Please Print Name}

____
{Signature of Patient or Parent/Guardian}

____
{Date}

For Office Use Only

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)

____

____

____

358 NAUGHRIGHT ROAD * LONG VALLEY, NJ 07853-3806 * (908)852-1100
www.cazesfamilydentistry.com

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.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/20/2013, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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, and certification, licensing or credentialing activities.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for 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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.50 for each page, $30 per hour for staff time to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the

alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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 Cazes, DDS, FAGD**
Telephone: (908) 852-1100 Fax: (908) 852-2522 E-mail: DrJanice@Cazesfamilydentistry.com
Address: 358 Naughright Road, Long Valley, NJ 07853-3806