PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

1

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.	CELL#		
E-MAIL:			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.			
E-MAIL:			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

4 ACCOUNT INFORMATION

NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Please turn over and sign

TREATMENT AND FINANCIAL CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that I can ask for complete recital of risks and benefits of any treatment rendered.
3. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf, my spouse or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in writing and are signed by this office and the parent/ responsible party. If we do not receive payment at the time of service and there is no arrangement made in writing, I understand that interest will begin to accrue on any remaining balance on my account 30 days after the date of service at the rate of 1.5% per month (18% per annum). I understand that interest will continue to accrue at this rate until the remaining balance is paid in full. I also understand that if any account is placed with an attorney or collection agency because of any unpaid balance remaining on my account, I hereby agree and promise to pay a one-time collection fee of $100.00 or 30% of any unpaid balance on my account at the time of placement with the attorney or collection agency, whichever is greater.
5. For those patients who are covered by insurance, we will accept assignment of benefits as a courtesy. Most dental insurance plans do not cover 100% of the cost of your dental treatment. Because of the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and a portion of your charges the day the services are rendered. We will ESTIMATE as closely as possible your coverage, but until we actually receive the payment from the insurance company, it is just an ESTIMATE.
6. A $30.00 service fee will be charged for any returned checks.
7. We take much pride in the fact that a majority of the time our patients do not have to "wait" in the waiting room. We believe your time is as valuable as ours. **If an appointment is canceled without 48 hour prior notice or a patient does not show for an appointment, a $75.00 fee will be charged.** This payment will be sent to the Food Bank of Monmouth and Ocean Counties. With respect to subsequent cancellations or broken appointments, the patient will be seen at the doctor's convenience.

We appreciate your cooperation with regards to these matters. Our office runs more smoothly with your help and therefore enables us to give our patients optimal treatment.
The undersigned has read and understands the above consent for treatment and policies and agrees to all the terms set forth above.

Signature_____ **Date**_____ **Witness**_____
Parent/Responsible Party's Signature_____
Relationship to patient_____

PHOTO RELEASE

Your signature below indicates your consent for Drs. Graber and Peters to use or reproduce photographs or computer illustrations of your teeth for educational or marketing purposes. You waive claim that the use of images defames you or constitutes an infringement of your rights to privacy. It is not mandatory that you sign this paragraph and you agree that if you choose to sign it is done freely and voluntarily.
Signature_____ **Date**_____

Patient Name	**MEDICAL HISTORY**
Todays Date	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or supplements now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/ Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Are you taking any blood thinners or aspirin? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

HAVE YOU OR ARE YOU CURRENTLY TAKING MEDICATION FOR OSTEOPOROSIS? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ **Date** _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Bear Brook Commons Dental Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{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)

_____

_____

_____

DR. WAYNE GRABER & DR. BRIAN M. PETERS, P.A.
COSMETIC, IMPLANT AND FAMILY DENTISTRY

TO OUR VALUED PATIENTS

This year marks the beginning of many exciting changes in our office in our effort to improve service and quality of care for you so that you can regain and maintain your health as quickly and inexpensively as possible.

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. If you cannot keep your appointments and adhere to our treatment recommendations, we will not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. **Cleanliness and infection control** are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. We request that you brush your teeth prior to coming in for your scheduled appointment. _____**Initial**

2. **Timeliness** is required. We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 15 minutes late, we may have to reschedule your appointment._____**Initial**

3. **Missed Appointments** - If you missed an appointment you must reschedule as soon as possible. It is critical to your health to do so in order to avoid setbacks in the care and maintenance of your teeth and gums. _____**Initial**

4. We pride ourselves on providing our patients with quality dental care at each visit. We schedule appointments to give ample time to the doctor/hygienist to render necessary treatment. Failure to keep your appointment compromises your dental health and also denies other patients of their treatment. For these reasons, **no shows are unacceptable**. We ask that you contact the office at least 48 hours prior to an appointment if you must cancel or reschedule. There is a $75.00 charge for broken appointments. Any payment received for a broken appointment will be donated to The Food Bank of Monmouth and Ocean Counties and we ask that any checks be made payable to this organization. Broken appointment fees are not covered by insurance._____**Initial**

5. **Insurance**: treatment recommendations are based on your health, **NOT** on your insurance or lack thereof. Our office prides itself on recommending the very best treatment and the highest quality care. Unfortunately most insurance companies are not concerned about your health. We will file insurance claims for you, however you are responsible for any deductibles and charges which are due as your treatment is rendered. Remember – Any fee quoted to you that involves insurance is only an ESTIMATE.
_____**Initial**

6. We run a **Zero Balance** office. We expect payment in full prior to or at the time treatment is provided. We have several financial options available for all of our patients. Please ask us if you have any questions._____**Initial**

7. **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._____**Initial**

8. It is our office policy to ensure the **complete satisfaction** of all of our patients with the service and care they receive here in 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 make things right by you. Should an upset occur, provided you bring it to our attention in an appropriate, cordial manner, we can give the matter the proper attention it deserves for an effective resolution. Our staff will treat you with professional demeanor and efficiency, as you should expect and deserve. Please see our office manager immediately to resolve any upsets you may have with our office or any one of our team.
_____**Initial**

9. **Emergencies**. It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured, that we will take care of you. In order to do this we would like to define what a true emergency is. Swelling, bleeding or severe pain that has kept you up at night, requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies._____**Initial**

We greatly appreciate your cooperation.
Yours in Health,

Dr. Wayne Graber
Dr. Brian M. Peters

_____
Signature