Dayspring Dental

"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

Date _____ Home Phone _____

Patient's Name _____ Cell Phone _____

Preferred Name _____ M ◯ F ◯

Birth date _____ Social Security # _____

Name of Spouse _____ Parents, if Child _____

Street Address _____

City _____ State _____ Zip _____

Email _____

Patient or Parent Employed By _____

Business Address Including State & Zip _____

Business Phone _____

Present work Position _____ Years Held _____

Patient or Parent Employed By _____

Business Address Including State & Zip _____

Business Phone _____

Present work Position _____ Years Held _____

Emergency Contact _____ Phone _____

Purpose of Appointment _____ Who Will Pay This Account _____

Parents Date of Birth (father) _____ (mother) _____

If Using Charge Card, Name _____ Account Number _____

INSURANCE INFORMATION

Primary Company _____ Policy Holder _____

Address of Company _____ Phone _____

Policy Holder SS# _____ Policy or Group # _____

Secondary Company _____ Policy Holder _____

Address of Company _____ Phone _____

Policy Holder SS# _____ Policy or Group # _____

Who May We Thank For Referring You _____

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental

"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

MEDICAL HISTORY

Today's Date _____ Date of Birth _____

PATIENT'S NAME _____ Current Age _____ M ◯ F ◯

Date of last medical exam _____ Purpose of exam _____

Have you been hospitalized in the last 5 years? YES NO

If so, for what? _____

Do you or have you ever had: Please check all that apply.

Diabetes/pre diabetes ☐	Acid reflux/ GERD ☐	Heart attack ☐
infectious disease, HIV ☐	Sleep apnea ☐	Stroke/TIA ☐
Thyroid disease ☐	Problems swallowing ☐	Heart valve replacements ☐
Cancer ☐	Prosthetic joint ☐	Lung disease ☐
Substance abuse ☐	Psychiatric treatment ☐	Seasonal allergies ☐
Headaches/migraines ☐	STD ☐	Latex allergy ☐
Epilepsy ☐	Kidney disease/stones ☐	Sinus problems ☐
Neurological disorders ☐	Endocarditis ☐	Asthma ☐
Brain injury ☐	High/low blood pressure ☐	Arthritis ☐
Hepatitis/jaundice ☐	Anemia ☐	**Women:** Are you pregnant ☐
Tuberculosis ☐	Pacemaker ☐	Osteoporosis medicine ☐
Liver disease ☐	Heart disease ☐	Taking birth control ☐
Bleeding disorder ☐	Angina ☐	

Do you use tobacco YES ◯ NO ◯ For how long? _____ How much? _____

Any allergies/adverse reactions to medications? YES ◯ NO ◯

If so, to which medications): _____

Are you presently taking any medications? YES ◯ NO ◯ Names and dosages of medications (list below):

_____

Other physical conditions we should be aware of: _____

Name of family physician: _____ Phone# _____

Are you receiving any other health care? YES ◯ NO ◯

May we request your records? YES ◯ NO ◯

Signature: _____ Today's date: _____

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental

"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment of services is due at the time services are rendered. If you have dental insurance, you must make the estimated co-payments at the time of treatment, and you are totally responsible for anything the insurance company does not want to pay within 45 days after billing. We accept cash, personal checks, Visa, Master Card, Discover and American Express. We also offer the Citi Health Card, you can qualify for 3,6,12 or 18 month interest free financing, please ask for an application if you are interested. Returned checks and balances older than 30 days may be subject to additional collection fees. Charges may also be made for missed appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a Party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies select services they will not cover. You become financially responsible for these services.

3. Please be advised that this office does not place silver fillings in posterior (back) teeth. We only place white composite filling material, **99% of all insurance companies only allow for amalgam (silver) filling material, but will pay an alternate benefit for the silver. This means you the patient become responsible, for any difference.**

4. In cases of divorce or separation with children involved it is our office policy that the parent who has residential custody is responsible for paying any co-payment and or deductible at time of service. If insurance is involved and they pay less then expected, again the parent with residential custody is responsible for the balance. We will give the parent receipts to obtain reimbursement from other parties involved.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients; all charges are your responsibility from the date the services are rendered. If financial problems do arise we encourage you to contact our office promptly so that we may help you with the management of you account.

Again, thank you for selecting Dayspring Dental for your dental needs. If at any time you have a question regarding your treatment, fees or services please contact us promptly to discuss them.

By signing this paper you agree to and understand our payment policy.

Signature: _____ Date: _____

If you have dental insurance please sign and date below as "Signature on File" so that we may manually or electronically submit your dental claims on your behalf.

Signature: _____ Date: _____

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental
"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

PAYMENT OPTIONS

We feel that it is very important for us to provide you with the treatment that is wanted and needed, therefore, we have several payment options available for your convenience. Please indicate which option will work best for you.

INSURANCE:

☐ I do not have insurance to cover your fees.

☐ I have insurance coverage and would like you to file my claim and charge me for my estimated portion at the time of service.

☐ I have insurance coverage and will pay you directly then file my own claims for reimbursement.

For our patients with insurance, our professional services are rendered to you, not to your insurance company. We will do our utmost to help you derive the maximum benefits to which you are entitled; however, you are directly responsible to us for the obligation of payment for treatment.

OTHER PAYMENT:

I recognize that I am responsible for all fees related to my treatment. For that portion not covered by my insurance I will pay by:

☐ Cash or Check

☐ Visa, MC, American Express, Discover or Debit card

☐ Citi Health Card

- ☐ I have one, my account # is _____
- ☐ I wish to apply for one

☐ Lending Club

- ☐ I have one, my account # is _____
- ☐ I wish to apply for one

_____ _____ _____

Patient's Name (Please Print) Signature Date

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental

"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

DENTAL HEALTH QUESTIONNAIRE

It is important that we know about your Dental history. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to complete.

How long has it been since you've seen a dentist? _____

When was your last complete exam? _____ Full series of x-rays _____

Why are you at the dentist today? _____

What did you like most about your previous dentist? _____

What did you like least? _____

Do you believe your dental health is poor?	YES ◯	NO ◯	
Are you apprehensive about dental treatment?	YES ◯	NO ◯	
Have you ever worn braces?	YES ◯	NO ◯	
Have you had any periodontal (gum) treatments?	YES ◯	NO ◯	
Do your gums bleed?	YES ◯	NO ◯	
Do your gums feel tender or irritated?	YES ◯	NO ◯	
Are your teeth sensitive to hot or cold?	YES ◯	NO ◯	
Sensitive to sweets or pressure?	YES ◯	NO ◯	
Do you avoid chewing on one side of your mouth?	YES ◯	NO ◯	Why? _____
Do you have headache pain or ear aches?	YES ◯	NO ◯	
Do you wear dentures? (Partial or Full)	YES ◯	NO ◯	
Are you unhappy with your dentures?	YES ◯	NO ◯	
Care to know more about permanent replacements?	YES ◯	NO ◯	
Are you unhappy with your appearance?	YES ◯	NO ◯	

If so, what would you change? _____

Are you unhappy with the way your teeth look?	YES ◯	NO ◯
Do you have discolored teeth?	YES ◯	NO ◯
Would you like your smile to look better?	YES ◯	NO ◯
Do you floss regularly?	YES ◯	NO ◯

When do you brush? _____

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment:

FEAR of pain _____ COST of treatment _____

LACK of concern _____ MISSING work time _____

Are you aware of or ever been told that you snore? YES ◯ NO ◯

_____ _____

Patient signature (or Parent if Minor) Date

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
daysprингdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental
"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

Website / Social Media PERMISSION SLIP

May We Share Your Photos?

Please check a box below

On Our Website? ☐

On Social Media? ☐

Use of facial photo: ☐

Mouth & teeth photo only: ☐

Use of both above: ☐

Name: _____ Date: _____

_____
Signature:

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental
"Because your smile brightens the world"
General Dentistry, Implants, Orthodontics

PLEASE HELP US UPDATE OUR RECORDS & KEEP YOU UPDATED ON ALL THE LATEST AT DAYSPRING DENTAL

DATE: _____

PATIENT NAME: _____

E-MAIL ADDRESS: _____

CURRENT CELL PHONE #: _____

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental

"Because your smile brightens the world"

General Dentistry, Implants, Orthodontics

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Privacy Officer,

DATE:

PATIENT NAME: (print): _____

DATE OF BIRTH: _____

_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

Understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

_____ _____

Signature: Date:

_____

Relationship to patient (if signed by a personal representative of patient):

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com

Dayspring Dental

"Because your smile brightens the world" General Dentistry, Implants, Orthodontics

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- ☐ Home Telephone
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number

- ☐ Work Telephone
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

- ☐ Other _____

_____

_____

_____ _____

Patient's Signature Date

_____ _____

Print Name Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.
Record of Disclosures of Protected Health Information

Date	Disclosed to whom address or fax number	Description of disclosure/purpose of disclosure	By whom disclosed

428 Ganttown Rd.
Sewell, NJ 08080

Matthew F. Bickel, D.M.D. "Dr. Matt"
Kathleen J. Bickel, D.M.D. "Dr. Kathy"

856.875.8400
dayspringdentaltwp.com
info@dayspringdentaltwp.com