

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 \_\_\_\_\_



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 _____	<b>Women:</b> 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): \_\_\_\_\_

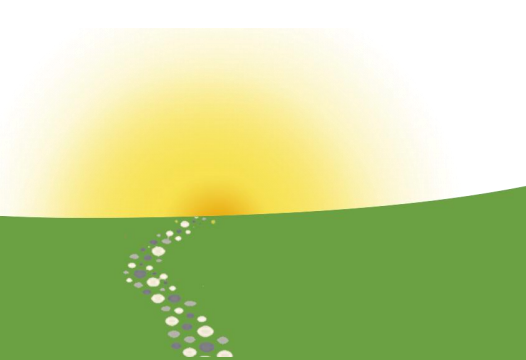
Other physical conditions we should be aware of: \_\_\_\_\_

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: \_\_\_\_\_



# 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: \_\_\_\_\_



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.

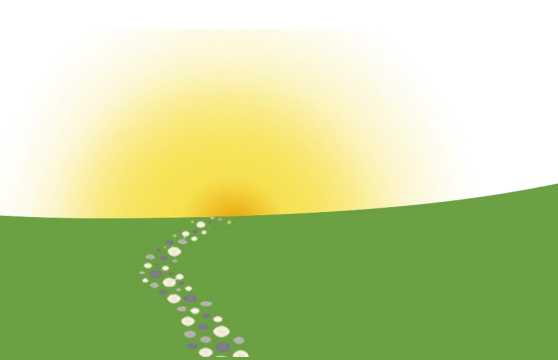
For our patients with insurance, our professional services are rendered to you, not to your insurance company. We will do our utmost to help you derive the maximum benefits to which you are entitled; however, you are directly responsible to us for the obligation of payment for treatment.

**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



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



## Website / Social Media PERMISSION SLIP

### May We Share Your Photos?

Please check a box below

On Our Website? \_\_\_\_\_

On Social Media? \_\_\_\_\_

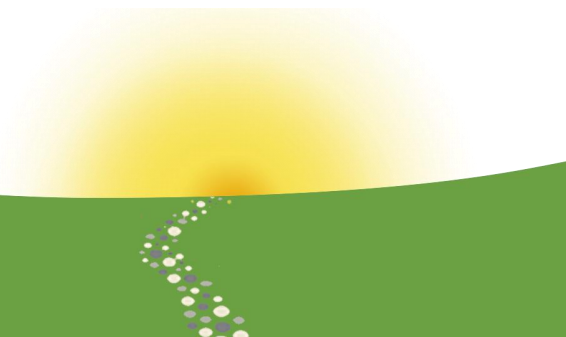
Use of facial photo: \_\_\_\_\_

Mouth & teeth photo only: \_\_\_\_\_

Use of both above: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature:



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: \_\_\_\_\_

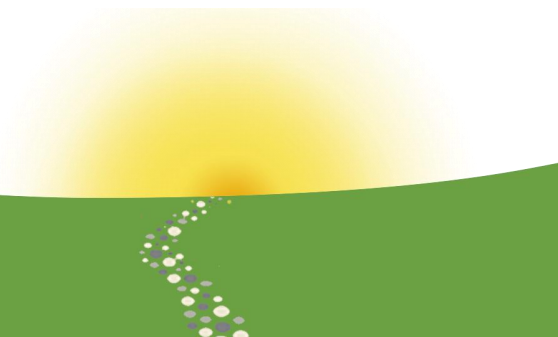
I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with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





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)*

<input type="checkbox"/> Home Telephone <input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Written Communication <input type="checkbox"/> OK to mail to my home address <input type="checkbox"/> OK to mail to my work/office address <input type="checkbox"/> OK to fax to this number
<input type="checkbox"/> Work Telephone <input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> 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

