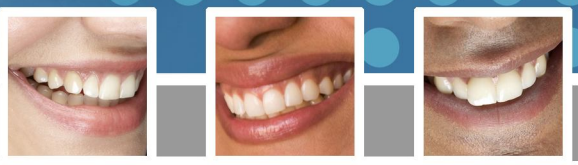
Bayside Family Dentistry of Cape May
Heather J. Olson, D.M.D., P.A.
204 Townbank Road
N. Cape May NJ 08204
(609)886-5255



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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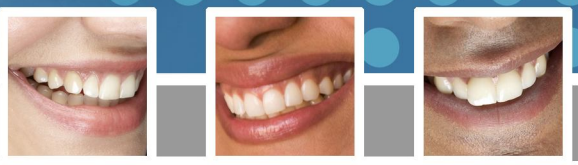

Spouse or Guardian or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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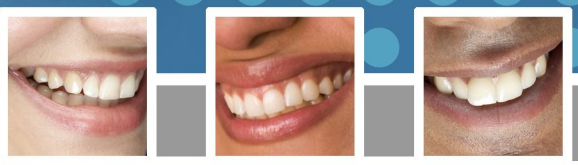

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

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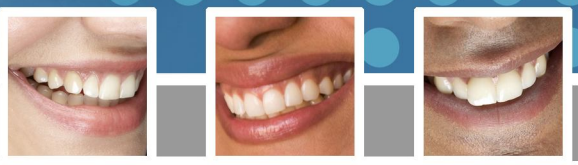

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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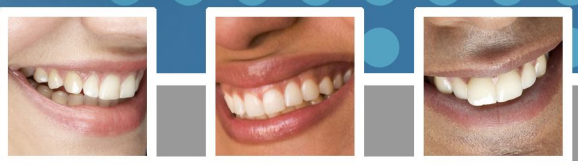

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

Artificial Heart Valve

* ◯ Yes ◯ No

Artificial Joints
:
Specify joint and date of surgery
_____

* ◯ Yes ◯ No

Cancer:
Specify type and treatment
_____

◯ Yes ◯ No

Chemotherapy:
Specify dates
_____

◯ Yes ◯ No

Anemia

◯ Yes ◯ No

AIDS/HIV

◯ Yes ◯ No

Arthritis, Rheumatism

◯ Yes ◯ No

Asthma

◯ Yes ◯ No

Blood Disease

◯ Yes ◯ No

Chemical Dependency

◯ Yes ◯ No

Circulatory problems

◯ Yes ◯ No

Congenital Heart Problems

◯ Yes ◯ No

Cortisone Treatments

◯ Yes ◯ No

Cough

◯ Yes ◯ No

Diabetes

◯ Yes ◯ No

Emphysema

◯ Yes ◯ No

Epilepsy

◯ Yes ◯ No

Fainting

◯ Yes ◯ No

Vertigo or Dizziness

◯ Yes ◯ No

Glaucoma

◯ Yes ◯ No

Headaches

◯ Yes ◯ No

Heart Murmur

◯ Yes ◯ No

Hepatitis Specify type

_____

◯ Yes ◯ No

Herpes

◯ Yes ◯ No

High Blood Pressure

◯ Yes ◯ No

Jaundice

◯ Yes ◯ No

Jaw Pain

◯ Yes ◯ No

Kidney Disease

◯ Yes ◯ No

Liver Disease

◯ Yes ◯ No

Mitral Valve Prolapse

◯ Yes ◯ No

Low Blood Pressure

◯ Yes ◯ No

Nervous Problems

◯ Yes ◯ No

Scarlet Fever

◯ Yes ◯ No

Shortness of Breathe

◯ Yes ◯ No

Sinus Trouble

◯ Yes ◯ No

Skin Rash

◯ Yes ◯ No

Special Diet

◯ Yes ◯ No

Stroke

◯ Yes ◯ No

Swollen Feet/Ankles

◯ Yes ◯ No

Thyroid Problems

◯ Yes ◯ No

Tonsillitis

◯ Yes ◯ No

Tuberculosis

◯ Yes ◯ No

Tumor, head or neck

◯ Yes ◯ No

Ulcer

◯ Yes ◯ No

Venereal Disease

Yes No

Weight Loss

Yes No

Pacemaker

Yes No

Swollen Neck Glands

Yes No

Psychiatric Care

Yes No

Radiation Treatment

Yes No

Respiratory Disease

Yes No

Rheumatic Fever

Yes No

Back Problems

Yes No

Bleeding Problems

Yes No

Are You Pregnant:
Due Date

Yes No

Please List all Medications

Allergies Circle all that Apply

Aspirin Latex Penicillin Sulfa
Barbiturates Codeine Iodine
Other please specify

Have you ever has a negative Reaction to LOCAL anesthesia? Please describe:

Do you need to premedicate for dental treatment?
Why?

◯ Yes ◯ No

Is there any additional health information you feel is significant for your dental treatment?

Is there any information revalant to your medical or dental history you have not included and do not wish to include but can share in confidence?

◯ Yes ◯ No

Response Date: