TODAY'S DATE _____

Welcome to Dr. Josephsen's Office – won't you please help us by completing the following information?
All answers are required and are held in the strictest confidence in compliance with HIPPA regulations.

Name_____ Home Telephone (_____)_____
First Middle Last

Home Address _____
Street Town State Zip

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

If Child, Parent's Names (Father)_____ (Mother)_____

[ ] Single [ ] Married Name of Spouse _____

Business Name and Address (of parent if child) _____

Business Telephone _____ Cell Phone_____

Email_____@_____

Name and Address of Physician _____

Referred to us by ? _____

Please Answer Each Question

Your present overall health is [ ] Good [ ] Fair [ ] Poor
Why?_____
__

Have you ever been treated by a physician ? [ ] No
[ ] Yes Why? _____

Have you ever been hospitalized ? [ ] No
[ ] Yes Why? _____

Are you taking any medicine or drug in the past 3 years ? [ ] No
[ ] Yes Which one(s) ?_____

Do you have any allergies to medicines, antibiotics, foods, or anything? [ ] No
[ ] Yes Explain _____

Please check box if you have, or if have you have ever had, any of the following:

[ ] Rheumatic Fever or Rheumatic Heart Disease	[ ] Diabetes or Sugar	[ ] Asthma
[ ] Heart Murmur or Heart Valve Problem	[ ] Hepatitis or Jaundice	[ ] Sinus
[ ] Any Other Heart Problem or Symptom?	[ ] Anemia	[ ] Implants
What Is Your Blood Pressure? _____/_____	[ ] Any Infectious Disease?	[ ] Pacemaker

Please explain your answer(s) to the
above_____
_____

Please add any condition that you may have which is not listed above:

Continued >>>>>

We are happy to offer several options and methods of payment for your services from which you may choose. Please help us by completing the following information.

1. Do you have coverage under dental insurance ? [ ] No - proceed directly to #4 A below [ ] Yes

2. Under whose name is the PRIMARY DENTAL INSURANCE COVERAGE? [ ] Self
   [ ] Spouse or Parent Name of Insured_____
   Insured's Birthdate_____Insured's Social Security _____-___-_____

   Primary Insurance Company Name_____
   Primary Insurance Company Address_____
   Employer Name and Address _____
   Primary Insurance GROUP PLAN NUMBER _____

3. Is patient covered under any other dental insurance plan? [ ] No [ ] Yes
   Under whose name is this other coverage? _____
   What is their Birthdate?_____ What is their Social Security? _____-_____-_____

   Secondary Insurance Company Name_____
   Secondary Insurance Company Address_____
   Employer Name and Address of Secondary Coverage _____
   Secondary Insurance Company GROUP PLAN NUMBER_____

   All fees for services are entered immediately upon the completion of those services. We are glad to assist you in processing your dental insurances (in fact, we insist on it!). Your Insurance Plan is an agreement between you, your employer, and your insurance carrier, and it is the patient who is responsible for payment of their services. Dollar amounts and percentages of reimbursement will vary significantly with the particular insurance carrier, the premium that is paid for your coverage, and factors such as insurance company reimbursement schedules, to which we, as your provider, are not privy.

4. **Kindly select either A,B or C from the following options by checking the appropriate box**:

A [ ] Payment for your services in the form of personal check, cash, or credit card will be requested at the completion of each appointment.

B [ ] If you are covered by dental insurance, payment for your services in the form of personal check, cash, or credit card will be requested at the completion of each appointment. We will process and submit your plan's paperwork immediately on your behalf, and all reimbursement from your insurance company will then be sent directly to you, the patient, from your carrier.

C [ ] If you are covered by dental insurance, as an additional courtesy and service to our patients, we will continue to offer the option of having your dental insurance payments sent directly to the office.

In order for you to utilize this payment option, you must now pre-authorize us to charge to your credit card any balance that remains after any insurance payment is received. A copy of the completed credit card transaction will then be mailed from our office directly to you for your records. By checking this box and signing the form below, you so authorize us to charge any balance to your card on your behalf, until such time as this authorization is changed, by you, in writing.

Informed Consent:

- I understand that I will be informed of all dental treatment options appropriate to my case. Whenever choices in treatment may exist, treatment options will be explained to me during consultation, after which I may then make an informed decision and choice of treatment.
- I will not allow any procedure or any part of a procedure to begin until I am satisfied that all appropriate options have been explained to my satisfaction and until I understand the risks and benefits of each option and component of my treatment, including non-treatment or my refusal of necessary, recommended treatment.
- I consent to the following general dental treatment:
- Diagnostic, Radiographic, Photographic and Hygiene Treatment, and Preventive Modalities including prophylaxis, scaling and root planning, and other recognized preventive measures such as sealants and fluoride as may be indicated. My photos and case may be published confidentially.
- The treatment of diseased, discolored, or injured teeth by means of Direct or indirect Dental Restorations. When there are choices of direct filling materials, I consent to and prefer that non-metallic, bonded composite ("white") fillings be used where possible. I consent to the use of dental amalgam ("silver") fillings where required. In cases where there is inadequate tooth structure remaining to otherwise hold a filling in place, then I consent to the use of an indirect Crown / Inlay / Onlay Restoration, using gold, porcelain or composite materials as recommended. Possible complications include restoration or tooth failure and reversible or irreversible tooth/nerve sensitivity, related to the amount of missing/decayed tooth structure and the subsequent size/depth of the required restoration.
- Replacement of missing teeth via Removable Prosthetics (full or partial denture) or Fixed Prosthetics (implant or bridge) or combinations of both as needed. Possible complications in addition to above involve crown color and positioning as determined by surrounding teeth and bite.
- Extraction of non-restorable, periodontally diseased, or impacted/orthodontically involved teeth under local anesthesia as required. Possible complications involve tooth/root fracture or the need to access the tooth/root by soft tissue elevation.
- Endodontic treatment (root canal) for the treatment of exposed, infected, or irreversibly sensitive tooth nerves. Possible complications include broken or aspirated files, the inability to completely remove all soft tissue from within the tooth, unresolved infection, and the occasional failure of treatment under ideal circumstances and results, for unexplainable reasons which may include complete or partial tooth fracture, advanced infection, or inaccessible tooth nerve(s).
- Minor Orthodontic diagnosis and tooth movement, and vital and non-vital bleaching procedures.
- Minor Periodontal therapy, the goal of which is the long term preservation of gum and bone, to include preliminary diagnosis, deep scaling and root planing procedures under local anesthesia, and other antimicrobial modalities.
- I recognize that there are risks inherent in all treatment, including non-treatment, including but not limited to the administration of local anesthesia by injection ("novocaine"), which may produce swelling, bleeding, pain, numbness, bruising, and in very rare instances allergy, paresthesia (long-term numbness), and cardiac arrest that could possibly result in coma or death.

- I understand that unforseen, undiagnosed complications may arise during treatment, which may alter the course and prognosis/outcome of the original treatment as proposed, and that while recommended treatment is to my benefit, no guarantees may be made as to prognosis or outcome. Common risks, complications, and prognosis will be explained to my understanding and satisfaction before I initiate any treatment or permit treatment already underway to continue.

- And so I hereby certify that all information that I have provided in this history and financial/insurance documentation is correct, and that I have read and understand this consent form, and I hereby authorize and consent to all dental treatment deemed necessary and performed by Dr. Josephsen and his licensed auxiliaries, and I agree that this consent is perpetual for all treatment rendered.

- The scope of this authorization shall not be limited to the above treatment as described but shall apply to all treatment to which I consent, and I will at all times fulfill my responsibilities of due diligence as a reasonable and prudent patient/parent/guardian. I understand that it is both my right and my responsibility to ask any and all questions pertinent to my treatment, and to alert Dr. Josephsen to any changes in my condition or in the information provided.

_____ _____ _____

Please print name Signature (of parent/guardian if minor) Date

ALFRED P. JOSEPHSEN, D.M.D., F.A.G.D. 31 HARRISON AVENUE, WEST CALDWELL, N.J. 07006

Name_____

Authorization for Credit/Debit Card use for automatic payment

[ ] **Visa** Card Number_____Security_____
Cardholder Name_____Expiration_____

[ ] **Mastercard**
Card Number_____Security_____
Cardholder Name_____Expiration_____

[ ] **Discover**
Card Number_____Security_____
Cardholder Name_____Expiration_____

[ ] **American Express**
Card Number_____Security_____
Cardholder Name_____Expiration_____

CARDHOLDER SIGNATURE_____