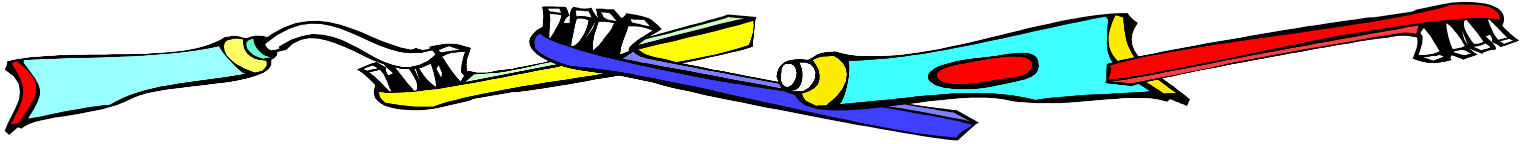
Welcome

We are happy to welcome you to our office. Please take a few minutes to fill out this form. If you have any questions, we'll be happy to help you. Our goal is to help you reach and maintain maximum oral health.



Please complete both sides of this form

ABOUT YOU

Today's Date:__________________ Email:______________________________

Name:____ Male___Female___ Birthdate:____/_____/____
(Last) (First) (MI)

I prefer to be called:________________________ Social Security #:__________________________

Single____ Married____ Widowed____ Divorced____ Separated____ Student____

Home Phone:________________________________ Cell phone:______________________________

Home Address:____

City:______________________________________ State:________________ Zip:__________________

Employer:____ Occupation:__________________________

Employer's Address:____________________________________ Work Phone:__________________________

Whom may we thank for referring you?____

In case of emergency, who should be notified?__________________________________ Phone:______________

INSURANCE COVERAGE

Person Responsible for Account:____
(Last) (First) (MI)

Relationship to Patient:________________________Birth Date:____/____/____ Soc. Security #:__________________

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone:______________________________________ Group#:__________________________

Insured's Name:______________________________________ Relation to Patient_____________________________

Insured's Address (if different from patient):____

Insured's Birth Date:____/____/____ Insured's SS#:_________________ Insured's ID #:__________________

Employer Name:_____________________________Address:____

SECONDARY INSURANCE (if applicable)

Insured's Name:______________________________________ Relation to Patient:____________________________

Insured's Address (if different from patient):____

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone:___________________________________ Group #:____________________________

Insured's Birth Date:____/____/____ Insured's SS#:____________________ Insured's ID#:__________________

Employer Name:_____________________________Address:____

The above information is critical for proper reimbursement by all insurance companies.

(Continued on back)

DENTAL HISTORY

Reason for Today's Visit:____

Former Dentist:__________________Phone:____________________Address:__________________________________

Date of last dental visit:__________________________________Were x-rays taken?__________________________

Do you require antibiotics before dental treatment? **Yes/ No**

Are you currently in any pain? **Yes/ No** Explain:____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? **Yes/No**

Do you clench or grind your teeth? **Yes/No**

Do you get frequent headaches? **Yes/No**

Have you noticed loose teeth? **Yes/ No**

Do you still have your wisdom teeth? **Yes/ No**

Have you noticed mouth odors? **Yes/ No**

Do your gums bleed or hurt? **Yes/No**

How many times a day do you brush?________

How many times a week do you floss?________

Have you ever seen a Periodontist? **Yes/ No** Please explain:____

Have you ever had Orthodontic treatment? **Yes/ No**

Would you like whiter your teeth? **Yes/ No**

Are you anxious about dental treatment? **Yes/No** Please explain your biggest concern:_______________________

____

Have you ever had an upsetting dental experience or problems with previous dental work? **Yes/ No**

Please explain:____

Are you happy with your appearance of your teeth? **Yes/ No** If not, what would you like to change?_________

____

MEDICAL HISTORY

Primary Physician:__________________________ Date of last visit_____________ Phone #:____________________

Specialist:_________________________________ Date of last visit_____________ Phone #:____________________

Your current health is: **Good / Fair / Poor**

Are you taking any prescription, over the counter or herbal supplement drugs? **Yes/ No**

Please list each one:____

____

Do you smoke or use tobacco in any other form? **Yes/ No** If yes, how much?____________________________

For women: Are you pregnant? **Yes/No** (Due Date____) Nursing? **Yes/No** Taking birth control pills? **Yes/No**

For Children: Does child use a pacifier? **Yes/ No** Suck Thumb? **Yes/ No** Use a Bottle? **Yes/ No**

Have you been admitted to a hospital or needed emergency care during the past 2 years? **Yes/ No**

If yes, please explain:____

Have you ever had any of the following diseases or conditions: (Please circle all that apply.)

Abnormal Bleeding
Acid Reflux/Heartburn
Alcohol/Drug Abuse
Anemia
Arthritis
Artificial Bones/ Joints/ Valves
Asthma
Blood Disease/Transfusion
Cancer/Chemotherapy____________
Congenital heart defect
Diabetes (Type:__________)
Difficulty Breathing/Dizziness
Emphysema
Epilepsy
Excessive Bleeding
Fainting
Frequent Headaches

Glaucoma
Growths
Hay Fever
Head/Neck Injuries
Heart Attack
Heart Murmur
Heart Surgery
Heart Problems
Hemophilia
Hepatitis
Herpes/Fever Blisters
HIV/AIDS
High Blood Pressure
Jaundice/ Kidney Disease
Light sensitivity
Liver Disease
Low Blood Pressure

Mental Conditions
Mitral Valve Prolapse
Nervous Disorders
Pacemaker
Pregnancy
Radiation Treatment
Respiratory Problems
Rheumatic/Scarlet Fever
Seizures
Shingles
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis
Tumors
Ulcers
Venereal Disease

Please list any serious medical conditions:____

Are you allergic to any of the following: (Please circle all that apply.)

Aspirin
Dental Anesthetics
Erythromycin
Latex
Penicillin
Codeine
Dyes /Metals
Tetracycline
Other:____

Have you ever had Botox or Dermal fillers? YES/NO Are you interested in more information? YES/NO

Anthony Cannilla, D.M.D.

170 Changebridge Road, Suite A4-1, Montville, New Jersey 07045
(973) 227-3313 www.cannilla.com (973) 882-1516

Consent for Services

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

All emergency dental services, or dental services without previous financial arrangements, must be paid for in cash, check or credit card at the time services are performed.

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

A late fee of $25 may be charged to your account for unpaid balances exceeding 30 days. A service charge of 1 ½% 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 the office may charge me a cancellation fee for any last minute cancellations and broken appointments.

I understand that the fee estimate listed 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 profession services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or within ten (10) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or conditions hereafter shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney and collection fees if suit be instituted.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

______________________________ ______________________________
(Signature) **(Date)**

Authorization to Release Information

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

______________________________ ______________________________
(Signature) **(Date)**

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Written Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is unique. For this reason, we provide a variety of payment options to help you receive the dental care you need and deserve.

Payment is due at time of service unless prior arrangements have been made.

Payment Options: Please indicate which of the following fits your needs

Cash, Check, Visa, and MasterCard

Automated Monthly Credit Card Payment (ask for more details)

NO INTEREST Payment Plans from CareCredit

- A dedicated line of credit for your healthcare needs
- Interest free payment plans up to 18 months
- Extended low interest payment plans up to 60 months
- Monthly payments as low as 3.75% of the outstanding balance
- No annual fee or prepayment penalties

Office Payment Plan (out of pocket exceeding $1200.00): for crowns, bridges and dentures

- An initial payment of 1/3 of the scheduled treatment to be paid at the time of service by cash, check or credit card.
- Second payment of 1/3 at the second scheduled appointment, no more than one month following the initial payment.
- Final payment of 1/3 paid no than one month following the final appointment.

Insurance: We are happy to work with your insurance carrier to maximize your benefits and directly bill them for reimbursement. We will provide you with an estimated copayment which is due at time of service.
If for any reason the estimated portion is less than estimated or not paid by your insurance company, it becomes your obligation and we will bill you for the difference

Discounts for Patients without Insurance Coverage
Full Pay Discount: We offer a 15% courtesy for treatment exceeding $1200.00 if paid in full by cash or check at time of service.
Senior Citizen Discount: We offer senior citizens a 15% courtesy on all treatments if paid by cash or check.

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $35.00/hour cancellation fee. (Emergencies are exceptions)

Signature____ Date__________________________