Anthony Cannilla, D.M.D.

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

Welcome

We are happy to welcome you to our office. Our mission is to help you keep your teeth for a lifetime. To reach this goal, we will explain your treatment options and help you decide which treatment is best for your lifestyle. 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

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:_____ **Date of last dental visit:**_____ **Were x-rays taken?**_____

Do you require antibiotics before dental treatment? Yes/ No

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

Are you anxious about dental treatment or had an upsetting dental experience? Yes/No

Please explain:_____

What could you change about your smile?_____

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

Have you ever had Botox/Dermal fillers? Yes/ No **Are you interested in more information? Yes/ No**

MEDICAL HISTORY

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health conditions or medications may interact with the dentistry you will receive. Please answer the following:

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 medicine, 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?_____

Are you using recreational drugs or alcohol? Yes/ No Please elaborate:_____

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

ADD/ADHD	Cancer Treatment: Radiation	Hay Fever	Nervous Disorders
AIDS/HIV positive	Cancer Treatment: Surgery	Head/Neck Injuries	Parkinson's disease
Abnormal Bleeding	Cerebral Palsy	Heart Attack	Pregnancy
Acid Reflux/Heartburn	Cleft Palate	Heart Murmur	Psychiatric Conditions
Alcohol/Drug Abuse	Congenital heart defect	Heart Pacemaker	Respiratory Problems
Alzheimer's disease	Convulsions	Heart Surgery	Rheumatic/Scarlet Fever
Anaphylaxis	Diabetes	Hemophilia	Seizures
Anemia	Difficulty Breathing/Dizziness	Hepatitis A, B, C	Shingles
Arthritis	Down syndrome	Herpes/Fever Blisters	Sinus Problems
Artificial Bones/Joints/ Valves	Emphysema	High Blood Pressure	Stomach/Intestinal Disease
Asthma	Epilepsy	Intellectual Disability	Stroke
Autism	Excessive Bleeding	Jaundice/Kidney Disease	Thyroid Problems
Blood Disease/Transfusion	Fainting	Light sensitivity	Tuberculosis
Bladder Disease	Frequent Headaches	Liver Disease	Ulcers
Cancer/Tumor	Genetic Disorders	Low Blood Pressure	Venereal Disease
Cancer Treatment: Chemotherapy	Glaucoma	Meningitis	Vertigo
Cancer Treatment: Drugs	Growths	Mitral Valve Prolapse	

Please comment or list any serious medical conditions:_____

_____

Have you ever taken Bisphosphonate, such as: Actonel, Aredia, Atelvia, Bonefos, Boniva, Didronel, Fosamax, Reclast, Skelid, or Zometa? Yes/ No If yes, please explain:_____

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

Aspirin	**Dental Anesthetics**	**Erythromycin**	**Latex**	**Penicillin**
Codeine	**Dyes /Metals**	**Tetracycline**	**Food**	**Other:**_____

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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 with balances over $1,000.**
  - A dedicated line of credit for your healthcare needs
  - Interest free payment plans.
  - Extended low interest payment plans up to 60 months
  - No annual fee or prepayment penalties

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.

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 $45.00/hour cancellation fee.

_____ **Date** _____
Signature of patient, parent or legal guardian

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.

_____ **Date** _____
Signature of patient, parent or legal guardian

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Consent for Services

With regards to treatment:

- I hereby authorize the designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I can ask for a complete recital on any possible complication.
- I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.
- I hereby give Dr. Cannilla the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right or future compensation in connection with the use of said photographs / slides.

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 patient's 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 $45 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.

_____ **Date** _____

Signature of patient, parent or legal guardian

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used to disclose by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

• **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

• **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• **Health care operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, cost-management analysis, and customer service. An example would be an annual quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Anthony Cannilla, D.M.D.
170 Changebridge Road, Suite A4-1
Montville, New Jersey 07045

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and individually.
- Obtain payment from third-party payers.
- Conduct normal health-care operations such as quality assessments and dentist certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of any health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to receive a current copy of the *Notice of Private Practices.* I understand that my request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list persons with whom we may discuss your health information: _____

_____ Date _____
Signature of patient, parent or legal guardian

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____Relationship:_____
Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer_____