PAUL FERRAIOLI, D.M.D., P.A.
P: 973-543-6666
F: 973-543-5702

3 Mountain Ave.
Mendham, NJ 07945
E-mail: drpaul@mendhamdentist.com

REGISTRATION

Mr./Mrs./Ms. _____ Employer _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Home Phone (_____)_____ Business Phone (_____)_____

E-mail: _____ Cell Phone: (_____)_____

Birth date _____/_____/_____ Social Security # _____/_____/_____

Dental Insurance Company (Primary) _____ Group# _____

Address _____ Subscriber# _____

Fax # (_____)_____ Phone # (_____)_____ E-Mail: _____

Dental Insurance Company (Secondary)_____ Group # _____

Address _____Subscriber# _____

Fax # (_____)_____ Phone # (_____)_____ E-Mail _____

Insured's name _____ Employer _____

Insured's birth date _____/_____/_____ Insured's Social Security # _____/_____/_____

I hereby authorize payment of dental benefits otherwise payable to me directly to Paul Ferraioli, DMD, PA.

_____ _____
Signature of Insured Date

Names of Dependent(s)	Social Security #	Birthdate	Primary/Secondary
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who can we thank for referring you? _____

I certify that I am the patient or authorized agent to furnish the information requested. I understand that although I may have dental insurance, I am responsible for payment of treatment.

_____ _____
Signature of Person responsible for account Date

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Health History Form

Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ Home Phone: _____Business/Cell Phone _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Height: _____ Weight: _____ Date of birth:_____ Sex: M F

SS# or Patient ID: _____ E-mail: _____

Emergency Contact: _____

Relationship _____Home Phone: _____ Cell Phone: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship _____

Medical Information

Please circle your response to indicate if you have or have not had any of the following diseases or problems.

Are you now under the care of a physician? …….. Y N DK

Physician Name: _____

Physician's Phone # _____

Address/City/State/Zip _____

Are you in good health? ..... Y N DK

Has there been any change in your general health within the past year …... Y N DK

If yes, what condition is being treated? _____

Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ……Y N DK

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? …….. Y N DK

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

(Circle DK if you Don't Know the answer to the question)

Do you wear contact lenses?..... Y N DK

Do you use controlled substances (drugs)? ..... Y N DK

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax), risedronate (Actonel), Didronel, Boniva, or Skelid for osteoporosis? …….. Y N DK

Do you use tobacco (smoking, snuff, chew, bidis) Y N DK
If so, how interested are you in stopping?
(Circle one) Very/ Somewhat/Not Interested

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications, resulting from Paget's disease, multiple myeloma or metastatic cancer?……Y N DK

Do you drink alcoholic beverages?…… Y N DK

If yes, how much do you typically drink in a week? _____

Date Treatment Began: _____

Do you snore ……Y N DK
Do you have sleep apnea ……Y N DK
If yes – have you had a sleep study? Y N
Date _____

WOMEN ONLY: Are you:
Pregnant?…….. Y N DK
Number of weeks: _____
Taking birth control pills or hormonal replacement .. Y N DK
Nursing?…….. Y N DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....……Y N DK
Date: _____ If yes, have you had any complications?_____

Allergies - Are you allergic to or have you had a reaction to:

To all **yes** responses, specify type of reaction.

Local anesthetics ……Y N DK
Aspirin ……..Y N DK
Penicillin or other antibiotics ……Y N DK
Barbiturates, sedatives, or sleeping pills ……Y N DK
Sulfa drugs …… Y N DK
Codeine or other narcotics …….. Y N DK

Metals …….. Y N DK
Latex (rubber) …… Y N DK
Iodine …….. Y N DK
Hay fever/seasonal …… Y N DK
Animals …… Y N DK
Food …… Y N DK
Other …… Y N DK

Please circle your response to indicate if you have or have not had any of the following diseases or problems:

Heart Murmur ……Y N DK
Mitral Valve prolapse …….Y N DK
Artificial heart valves …… Y N DK
Rheumatic Fever ……...Y N DK
Cardiovascular disease ……Y N DK
Angina ……Y N DK
Arterioscierosis ……..Y N DK
Congestive heart failure ….. Y N DK
Coronary artery disease ….. Y N DK
Damaged heart valves ……. Y N DK
Heart attack ……Y N DK
Low blood pressure ……. Y N DK
High blood pressure ……. Y N DK
Congenital heart defects ….. Y N DK
Defibrillator …….. Y N DK
Pacemaker …….. Y N DK
Abnormal bleeding ……Y N DK
Chest pain upon exertion …Y N DK
Recurrent Infections……Y N DK
Type of Infection: _____
Persistent swollen glands in neck ……...Y N DK
ADD …….. Y N DK

Anemia ……Y N DK
Blood transfusion ……..Y N DK
If yes date: _____
Hemophelia ……Y N DK
AIDS or HIV infection …Y N DK
Arthritis …….. Y N DK
Autoimmune disease …Y N DK
Rheumatiod arthritis …..Y N DK
Systemic lupus erythematosus …….Y N DK
Asthma ……Y N DK
Bronchitis ……Y N DK
Emphysema ……...Y N DK
Sinus trouble …….. Y N DK
Tumors ……Y N DK
Tuberculosis ……...Y N DK
Cancer/Chemotherapy/ Radiation Treatment ..Y N DK
Sleep disorder ……Y N DK
Kidney problems ……Y N DK
Night sweats ……..Y N DK
Severe headaches/ migraines ……Y N DK
Aspergers/Autism ……..Y N DK

Chronic Pain …….. Y N DK
Diabetes Type I or II ……. Y N DK
Eating disorder …….. Y N DK
Malnutrition …… Y N DK
Gastrointestinal disease ...Y N DK
G.E. Reflux/persistent heartburn …… Y N DK
Ulcers …… Y N DK
Thyroid problems …….. Y N DK
Stroke …… Y N DK
Glaucoma …… Y N DK
Hepatitis, jaundice or liver disease ……...Y N DK
Epilepsy ……...Y N DK
Excessive urination ……Y N DK
Fainting spells or seizures..Y N DK
Neurological disorders ….. Y N DK
If yes, Specify: _____
Mental health disorders ….Y N DK
If yes, Specify: _____
Severe or rapid weight loss. Y N DK
Sexually transmitted disease …… Y N DK
COPD Chronic Obstructive Pulmonary Disease……Y N DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....…… ……Y N DK

Name of physician or dentist making recommendation:_____ Phone:_____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Y N DK

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:_____ Date: _____

Signature of Dentist:_____ Date: _____

FOR COMPLETION BY Dr. Ferraioli & Hygiene Staff

Comments: _____

_____

_____

_____

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E-mail:

DENTAL HISTORY

Name: _____ Today's Date: _____

Presenting Problem (if any): _____

- Describe any current discomfort/problem/concern with your teeth, gums, or jaw joint (TMJ):

_____

- Previous dentist's name/address: _____

Date of last exam/cleaning: _____ May we request previous dental records? YES NO

Previous frequency of check-ups: 3mo 4mo 6mo other _____

Date of last x-rays: _____ Type: bitewings full mouth other _____

- Have you ever been treated for periodontal (gum) disease? (date) _____
- How do you feel about your smile? _____
- Have you ever bleached your teeth? YES NO
- Does dental treatment make you nervous? No Slightly Moderately Extremely
- How often do you floss? Daily Weekly As Needed
- How often do you brush each day? _____
- Do you use regularly (please circle)

mouthrinse	fluoride	rubber tip	waterpik
electric toothbrush	proxibrush	stimudent	other: _____

- Do you currently have (please circle):

bleeding, sore gums	unpleasant taste/bad breath	food impactions
frequent blisters	burning tongue/lips	change in bite
swelling/lumps in mouth	orthodontics (braces)	clenching/grinding
clicking/popping jaw	biting cheeks/lips	difficultyopening/closing jaw
loose teeth	tooth sensitivity: hot cold	sweets biting

IF COMPLETING DENTAL HISTORY FOR YOUR CHILD:

Is your child taking a fluoride supplement daily? YES NO DK
Is your drinking water fluoridated? YES NO DK

NOTE: When necessary and appropriate, we will apply fluoride, sealants, and take check-up x-rays for children. **Indicate any of these procedures you do not give permission for:**

_____

Signature of Patient/Guardian _____ Dated: _____

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Excellence In Dentistry

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCOLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law required us to maintain the privacy of your health information. The law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy policies, please contact us using the information listed at the end of this notice.

USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose heath information about you for treatment, payment, and health care operations. For example:

TREATMENT: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider treating you.

PAYMENT: We may use your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment.

HEALTHCARE OPERATIONS: We may use your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

ON YOUR AUTHORIZATION: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We may disclose your health information to a family member, friends or other person to the extent the necessary to help with your health care or with payment to your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may disclose or use information about you to notify or assist in notifying a person involved in your care, of your location or general condition.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

DISASTER RELIEF: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in the disaster relief efforts.
PUBLIC BENEFITS: We may use or disclose your medical information as authorized by law if deemed to be in the public's interest or benefit

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions, You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may - but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

DISCLOSURE ACCOUNTING: You have a right to receive a list of instances in which we or our business associates disclosed your health information over the last six years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information at the end of this notice for more information about fees.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on your behalf. Your request is not binding unless our agreement is in writing.

ALTERNATIVE COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide necessary explanation how you will handle payment under the alternative means or location, you request.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny you request under certain circumstances.

QUESTIONS AND CONCERNS

If you want more information about our privacy practices or have concerns/questions, please contact us using the information listed below.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations

You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with he address to file your complaint upon your request. We support your right to privacy of your health information.

PROVIDER CONTACT OFFICE: Richard Derrick D.M.D., F.A.G.D., P.A.
3 Mountain Avenue, Mendham, NJ 07945
TELEPHONE: 973-543-6666 **FAX**: 973-543-5702

WELCOME TO DR. FERRAIOLI'S OFFICE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996
HIPAA web-site: http:/www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I authorize Paul Ferraioli, DMD, PA to:

O Send me my appointment reminders via US mail
O Call my residence and work location and leave message on answering machines information pertaining to my dental appointments
O Call my residence and work location and leave message with persons information pertaining to my dental appointments

SIGNATURE
I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____
If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

You May Refuse to Sign This Acknowledgment*
REVOCATION OF CONSENT
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgment of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgment that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web-site for your records.

HIPAA web-site: **http:/www.hhs.gov/ocr/hippa/finalreg.html**

I have received acknowledgment of this office's Notice of Privacy Practices.

Signature _____ Date_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

For Office Use:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
O Individual refused to sign
O Communications barriers prohibited obtaining the acknowledgment
O An emergency situation prevented us from obtaining acknowledgment
O Other (Please Specify) _____