Dr. Samuel Romano, D.M.D.
120 Park Avenue
Madison, NJ 07940
www.DrSamRomano.com

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care and proud of our dedication to our patients. Our goal is to help you feel and look your best through excellent dental care.

Please complete the enclosed Patient Information Form before your arrival and bring it with you at the time of your appointment. Additionally, bring any applicable insurance cards or forms.

Included with this letter is a copy of the office's privacy policies and information about our financial and confirmation of appointment policies. Directions to the office are included. Please keep them for your records and contact us if you have any questions.

Because we reserve time especially for you, please notify us at least 48 hours in advance if you are unable to keep your appointment so that we may reschedule it at a more convenient time.

We look forward to meeting you and working with you to maintain your dental health.

Sincerely,

Samuel Romano, DMD

Enclosures: Patient Information Form
Financial and Confirmation of Appointment Policy Form
Directions
HIPPA Privacy Policy Form

PATIENT INFORMATION **Date**_____

NAME _____ Married__ Single__ Partnered__ Male__ Female__
ADDRESS _____
CITY _____ STATE_____ ZIP CODE_____
PHONE (Home) _____ (Work) _____
PHONE (Cell) _____ E-mail _____
BIRTH DATE _____ SS# _____
How would you prefer to be reminded of appts? __Email Only __Text Only __Email & Text __No reminder needed

PLACE OF EMPLOYMENT _____
IF FULL TIME COLLEGE STUDENT, SCHOOL NAME _____
DENTAL INSURANCE COMPANY_____ GROUP #_____
Has any member of your family ever been treated in our office? _____
Whom may we thank for referring you to our office? _____

Father (spouse/partner)	Mother (spouse/partner)	In an emergency, contact:
_____	_____	(outside of family/household)
Last First M	Last First M	
_____	_____	Name_____
Street City State/Zip	Street City State/Zip	
_____	_____	Phone_____
Home# Work#	Home# Work#	
_____	_____	
Birthdate SS#	Birthdate SS#	

AUTHORIZATION

I certify that I have read or have had read to me the contents of this form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member or his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. The information on this page and the dental/medical histories are correct to the best of my knowledge.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I understand that I am responsible for all costs of dental treatment. I hereby authorize my insurance benefits to be paid directly to the dentist. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I authorize that the doctor can use my records if he so determines.

I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I understand that I am responsible for keeping my scheduled appointments. As long as 48 hours notice of my need to change an appointment is given, there will be absolutely no charge. Should I contact the office less than 48 hours prior to my scheduled appointment, I will be responsible for a $100 charge.

I have had full opportunity to read and consider the contents of this Consent Form, the Financial and Need to Change Appointment Policy, and Notice of Privacy Policies

Signature_____ Date_____
Adult Patient___Father/Husband___Mother/Wife___Guardian___ State Drivers License_____

Person Responsible for Account: Patient___ Guardian___ Father(Husband)___ Mother(Wife)___

DENTAL HISTORY

NAME_____ DATE_____

Date of last dental visit_____ Date of last full mouth x-rays (20 x-rays or panoramic)_____

Name of your previous dentist_____ City, State_____

Do you have a specific dental problem? No___ Yes___ How long has it been present?_____

Does dental treatment make you nervous? No___ Slightly___ Moderately___ Extremely___

Have you ever had any serious trouble associated with previous dental treatment?_____

_____

Are you pleased with the appearance of your smile? Yes___ No___ If not, what would you like to change?_____

_____

If you have had any of the following dental care, please list the dentist and approximate dates:

- ✓ Periodontal (gum) treatment_____
- ✓ Orthodontic treatment (braces)_____
- ✓ Dental implants_____
- ✓ Oral surgery_____

	No	Yes		No	Yes
Have you whitened/bleached your teeth?			Difficulty opening or moving the jaws?		
Unpleasant taste of persistent bad breath?			Difficulty speaking or changes in your voice?		
Does food catch between your teeth?			Loose or separating teeth?		
Gums bleed when brushing/flossing?			Difficulty moving your tongue or "tongue tied"?		
Red, swollen, bleeding or sore gums?			Changes in the way your teeth fit together?		
Gums that have pulled away from the teeth?			Pain, tenderness, numbness in your jaw?		
Puss between the teeth and gums?			Persistent ear aches or headaches?		
Avoid any area when brushing or chewing?			Do you wear a night guard or retainer?		
Sensitivity to hot, cold, sweets, biting?			Any lumps, swellings or swollen glands?		
Do you clench or grind your teeth?			Sores, ulcers or rough spots in your mouth?		
Changes in tooth size/shape in last 5 years?			Missing teeth that have not been replaced?		
Clicking, popping or difficulty chewing?			Do you snore or have sleep apnea?		

Do you use tobacco in any form? No___ If yes, how much_____ How long_____

Did you use tobacco in the past? No___ If yes, how much_____ How long_____

Do you have a family history of oral cancer? No___ Yes___

Do you use candy, mints, or gum throughout the day? No___ Yes___

Do you sip soda, juice, coffee, or tea throughout the day? No___ Yes___

MEDICAL HISTORY

NAME_____ DATE_____

Do you see a physician regularly? No___ Yes___ If so, why? _____

Name:_____ Specialty:_____ Phone:_____ City:_____

Name:_____ Specialty:_____ Phone:_____ City:_____

Have you ever been hospitalized or had a major operation? No___ Yes___ Discuss_____

Have you ever had a serious injury to your head, neck or mouth? No___ Yes___ Discuss_____

List all medications taken including prescription, over-the-counter, herbal or holistic remedies, vitamins or minerals:

_____

Are you taking or have ever taken a bisphosphonate (ex: Zometa, Aredia, Fosamax, Boniva)? No___ Yes___

Are you on a special diet? No___ Yes___ Discuss_____

Are you allergic to any medications or substances? No___ Yes___ Please circle:

Codeine/other painkillers	Sulfa Drugs	Food	Fluoride	Aspirin/Ibuprofen
Penicillin/other antibiotics	Acrylic	Latex Rubber	Nitrous Oxide	Sedatitives/Barbiturates
Metals(gold, stainless steel, nickel)	Local Anesthesia(Novocaine,etc.)		Alcohol	Other_____

WOMEN (PLEASE CHECK) Pregnant/trying to get pregnant_____ Nursing_____ Oral Contraceptives_____
Are you on hormone replacement therapy? No___ Yes___

Do you require a premedication for dental visits? No_____ Yes_____
Do you have or have you ever had any of the following?

	Y	N		Y	N		Y	N		Y	N
Scarlet Fever			High Blood Pressure			Mental Health Care			Epilepsy/Seizures		
Heart Murmur			Low Blood Pressure			Ulcers/Acid Reflux			Fainting/Dizziness		
Rheumatic Fever			Asthma/Hay Fever			Stomach/Intestinal Disease			Hepatitis B,C(Serum)		
Artificial Heart Valve			Sinus Problems			Loss of Hearing			Hepatitis A(Infectious)		
Heart Pace Maker			Excessive Bleeding			Eye impairments			Yellow Jaundice		
Heart Surgery			Hemophilia			Glaucoma			Liver Disease		
Mitral Valve Prolapse			Bruise Easily			Headaches			Kidney Disease		
Artificial Joint			Blood Transfusion			Marked Weight Change			Renal Dialysis		
Rx Diet Drugs			Anemia			Hypoglycemia			Thyroid Disease		
Radiation Therapy			Leukemia			Arthritis/Gout			Lyme Disease		
Chemotherapy			Irregular Heart Beat			Tumors/Growths			Cortisone Medication		
Diabetes			Angina/Chest Pain			Emphysema			AIDS		
Congenital Heart Disorder			Stroke			Difficulty Breathing			HIV Positive		
Heart Attack/Failure			Cancer			Tuberculosis			Drug Addiction		

Do you have any disease, condition, or problem not listed above that you think I should know about? No___ Yes___

If yes, please explain:_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

Reviewed By:_____

Primary Dental Insurance Information

Patient's Name:_____

Insurance Company Name:_____

Claim Address:_____

Type of Plan: HMO PPO Other_____

Provider Service Phone #:_____

Employer:_____

Policy ID #: _____ Group Number_____

Name of Insured:_____

Insured's D.O.B._____

Relationship of Insured to Patient:_____

Samuel Romano, D.M.D.
120 Park Avenue, Madison, NJ 07940
973-377-7088

Financial Policy Statement

Payment for all procedures is due in full at the time of service. Payment may be made by cash, check or credit card. We also offer an extended payment plan through an independent company.
As a courtesy, we will file claims with your primary insurance provider. Full payment is still due at the time of service, and we will submit claims indicating that the insurance check be sent directly to you.

Please understand you own the policy; therefore, you may need to contact your insurance company or your human resources department for specifics on your policy. Each policy is different so you should get details regarding the percentages paid for services and the maximum yearly benefits allowed. It is important to understand that not all necessary recommended dental treatment is covered by insurance.

Confirmation and Need to Change Appointment Policy

In our practice, we assist patients with their responsibility to keep their appointments. Our standard policy is to send email and/or text confirmations 2 weeks prior to an appointment, but patients can choose the method they prefer. Please indicate your preferences below. For children's appointments, please indicate which parent should receive the confirmations. (Check all that apply):
__ Email only __ Text only __ Email and text __ No reminder needed
Email address: _____
Phone number for text: _____
Phone number for personal phone call: _____

Appointment time is reserved for you and we faithfully try to respect your valuable time by seating you promptly so we ask that you are on time to your appointments.
As long as we receive 48 hours notice of your need to change your appointment, there will be absolutely no charge. Should we not hear from you at least 48 hours prior to your scheduled appointment, there will be a $100.00 charge for your missed appointment.
Subject to change without notice

I certify that I have read the Financial Policy Statement, Confirmation and Need to Change Appointment Policy and Notice of Privacy Practices and understand their content. I understand that these policies apply both to me and any other family members, minors or dependents.

_____

Patient (or patient's representative) signature Date

Dr. Samuel Romano, D.M.D
120 Park Avenue
Madison, NJ 07940
973-377-7088

Signature Release Statement

Your signature is necessary for us to:

1. **Process all insurance claims**
2. **Ensure payment for services provided**
3. **Release medical information to insurance companies needed for the processing of your claims**
4. **Release information to other medical/dental providers or laboratories when necessary for your treatment**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information to other medical/ dental providers, as well as labs.

I assign all medical, dental and surcigal beneftes, including major medical benefits to which I am entitled, to Dr. Samuel Romano. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as vailid as the original.

Patient Name Printed_____

Patient Signature_____

Parent Signature (If Minor)_____

Witness_____

Date Signed_____

Samuel Romano, D.M.D
120 Park Avenue
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973-377-7088

RELEASE FORM FOR PREVIOUS DENTAL RECORDS

Date_____

Previous Dental Office Name:
Address:
Phone number:

I give permission to release my/ family dental records to:

____ Self

____ Dr. Samuel Romano
120 Park Avenue
Madison, NJ 07940
info@drsamromano.com

Patient Name:_____

Patient Signature:_____

Witness:_____

Directions to
Dr. Samuel Romano
120 Park Avenue, Madison, NJ 07940
973-377-7088

From Newark Airport:

Follow signs to I-78 West. Take I-78 West for approximately 9 miles to NJ 24 West. Follow directions from NJ 24 West below

From NJ 24 West:

Follow NJ 24 West to exit 2-A for Morristown Rt. 510 West (Columbia Turnpike).
Make a left at the first light onto Park Avenue. We are about one mile on the right side just after the Exxon Gas Station.

From I-287 South to North:

Follow I-287 North to exit 37 (24 East, Springfield). Take exit 2-A for Morristown/Rt. 510 West. At the first light make a left onto Park Avenue. We are about one mile on your right side just past the Exxon Gas Station.

From I-287 North to South:

Follow I-287 South to exit 37 (24 East). Take exit 2-A for Morristown/Rt. 510 West. At the first light make a left onto Park Avenue. We are about one mile on your right side just past the Exxon Gas Station.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authored federal officials health information required for lawful intelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patient under certain circumstances

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemails, text, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you $0.25 for each page, $10 per hour for staff time to locate and coy you information, and postage if you want the copies mailed. If you request an alternative formats, we will charge a cost based fee for providing your health information in that format. If you prefer, we will 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 a full fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last two years, but not before April 14, 2003. 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 request.

Restriction: You have the right to request that we place additional restriction on our use or discloser of your health information.

Alternative Communication: 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.

Amendments: You have the right to request that we amend you health information. You request must be made in writing. We may deny your request under certain circumstances

Electronic Notice: If you receive this notice on our web site or by electronic mail, you are entitled to receive this notice in writing.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us suing the contact information listed at the end of this notice. You may submit a written complain to the U.S department of Health and Human Services. We will provide you with the address to file your complaint with the U.S department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S department of Health and Human Services.

Contact Information:
Dr. Samuel Romano
120 Park Avenue
Madison, NJ 07940
973-377-7088
Fax 973-377-4722
Drsam@drsamromano.com