Dr. Christopher Di Turi, D.D.S.
Monmouth Dental Associates

59 Avenue At The Common – Suite 205
Shrewsbury, N.J. 07702
732-741-5533
www.monmouthdentalassociates.com

Patient Information

Name: _____
First Middle Last

Address: _____
Street Address City State Zip Code

Email: _____ **Home Phone** _____ **Cell Phone:** _____
example@url.com (555) 555-5555 (555) 555-5555

Birth date: _____ **Social Security:** _____
MM/DD/YYYY xxx xx xxxx

Marital Status: ☐ Married ☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Minor **Sex:** ☐Male ☐Female

Emergency Contact: _____
Name Home Phone Cell Phone

Insurance Information / Responsible Party

Name of Insured: _____ **Birth Date:** _____
First Middle Last MM DD YYYY

Relation to Patient: _____ **Social Security:** _____
Father, Spouse (etc.) xxx xx xxxx

Employer: _____
Name

Insurance Company: _____
Name Telephone # Policy/Subscriber ID #

Permission to Receive Prerecorded Message and/or Text Message and/or Emails

As a service to our patients, we may provide courtesy appointments reminder calls, text messages and emails. We also may place other important calls, text messages or emails using an automated message system. By providing your home or cell phone number, you consent to receiving reminder calls and text messages on that number.

This authorization permits us to leave messages, calls or text you on the phone number provided above. You are also authorizing us to utilize your emails for courtesy reminders and other important notifications. If you provide your cell phone number, you will receive automated or pre-recorded messages on your cell phone. We will not share your contact information with any other party and your contact information is only stored locally on our secured server.

Patient's Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. **Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving**. Thank you for answering the following questions.

Do you have or have you ever had the following:

Check if Yes		Check if Yes		Check if Yes	
AIDS or HIV infection?	☐	Eating Disorders?	☐	Pacemaker?	☐
Allergies?	☐	Epilepsy or Seizures?	☐	Persistent Cough?	☐
Anemia?	☐	Fainting or dizzy spells?	☐	Rheumatic Heart Disease or Fever?	☐
Arthritis, Rheumatism?	☐	Glaucoma?	☐	Scarlet Fever?	☐
Artificial Heart Valves?	☐	**Heart defect/heart murmur?**	☐	Sexually Transmitted Disease?	☐
Artificial Joints, or other implants?	☐	**Heart trouble, attack, or surgery?**	☐	Sinus Trouble?	☐
Asthma or Hay Fever?	☐	Heart surgery?	☐	Shortness of breath?	☐
Back Problems?	☐	Hepatitis, or liver disease?	☐	Stomach Ulcer?	☐
Chest Pain?	☐	**High/Low blood pressure?**	☐	**Stroke?**	☐
Chemical Dependency?	☐	Hives or skin rash?	☐	Swelling of feet, ankles, hands?	☐
Chemotherapy (cancer)?	☐	Hypoglycemia?	☐	**Thyroid problems?**	☐
Cold Sores/Fever Blisters?	☐	Kidney Trouble?	☐	Tonsillitis?	☐
Congenital Heart Problem(s)?	☐	Lung or Breathing problems?	☐	Tuberculosis?	☐
Cortisone Treatment?	☐	Mental health care?	☐	Tumors?	☐
Cough the produces blood?	☐	**Mitral Valve Prolapse?**	☐		
Diabetes?	☐	Nervousness?	☐		

Are you allergic to or have you had any reactions to:

	Yes	No		Yes	No
LATEX and/or RUBBER?	☐	☐	**PENICILLIN or other ANTIBIOTICS?**	☐	☐
SULFA Drugs?	☐	☐	BARBITURATES, SEDATIVES or sleeping pills?	☐	☐
ASPRIN?	☐	☐	Any metals (NICKEL, MERCURY, etc.)?	☐	☐
IODINE?	☐	☐	Local anesthetics (NOVOCAINE)?	☐	☐

OTHER (Please List):

Have there been any major changes in your general health with the past year? If yes, what?

_____

Are you taking any non-prescription or premedication medicine(s)? please list them below)

_____

_____

Have you even taken FOSAMAX, BONIVA, or other cancer medications with BIOPHOSPHONATES?: ☐

Have you ever taken FEN-PHEN/REDUX?: ☐

Do you use any tobacco products? (cigarettes, dips, vaping) ☐

WOMEN ONLY:	Yes		Yes		Yes
Are you pregnant?	☐	Are you on birth control?	☐	Are you nursing?	☐

Medical Authorization and Release

I certify that I have read and understand the above medical information and have been accurately answered to the best of my knowledge. **I understand that providing incorrect information can be dangerous to my health.**

I authorized this dental practice to release any information including the diagnosis and the records of any treatment or examination rendered to me, my spouse or my child during the period of such dental care to third party payors and/or health practitioners.

The providers at this dental practice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

If necessary, I authorize this dental office to discuss my treatment with my guardian/spouse or other family member who is listed below. I authorize this by signing and dating below:

Name of Authorized Individual	Relationship to Patient	Signature of Patient	Date of Authorization

Consent for Use and Disclosure of Health Information

By signing this form, you are giving consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to read our notice of privacy practices. Our notice provides a description of our treatment payment activities and healthcare information. A copy of our private practices can be requested, including any revisions of our notice, at any time by contacting our office at 732-741-5533. You have the right to revoke this consent at any time by giving written notice of your revocation submitted to our office. Please understand that the revocation of your consent will not affect any action we took in reliance to this consent before we received your revocation, and that we may decline to treat you and future treatments if you revoke this consent.

Dental Benefits Payment Authorization

Thank you for choosing our office for all your dental needs. The authorization below permits, if applicable, any Dental Benefits payments to be made directly to Monmouth Dental Associates' Dental Practice.

I authorize and request my insurance compan(ies), mentioned above, to pay directly to the dentists located at 59 Avenue at the Common, Shrewsbury NJ 07702, any insurance benefits otherwise payable to me if allowed by my group's insurance policy and the use of my signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. **I agree to be responsible for payment of all services rendered on my behalf or my dependents**.
In addition, I understand that if payment is not received by the provider listed above within 60 days of the billing date, I am personally responsible for making direct payment.

Exam and Necessary X-ray Policy

I, also understand that it is within my right to at any point to refuse to have an examination or necessary x-rays.

I understand that the office reserves the right to terminate our doctor-patient relationship if I do not have an examination or x-rays within a frequency as decided necessary by the dentist.

To ensure that we provide optimal dental care, we follow the American Dental Association recommended frequency for dental exams and xrays, which is as follows: that you have at minimum 1 dental examination and 1 set of xrays every calendar year to detect decay or any other dental issues. We may suggest more frequent xrays or examinations as determined by your dental condition.

Office Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to make sure you receive your maximum allowable benefits. We will be happy to help you process your insurance claim for reimbursement. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Regarding dental insurance, you must realize although having dental insurance is a great benefit, is that:

1. Your insurance, along with its benefits and policies, is **a contract between you, your employer, and the insurance company**.
2. **Not all services are covered benefits of all insurance policies and contracts**. Some insurance companies will arbitrarily select certain services that they will apply alternate benefits to, frequency limitations to or simply will not cover.
3. For all **uninsured patients or out-of-network policies**, full payment is due at time of service.
4. **You are ultimately responsible for informing us of any changes in your insurance plan or policy.** Failure to do so may result in denial of coverage and you will be held responsible for the fees.

We accept cash, checks and credit cards. An extended payment plan with any of our financial payment options is accepted as well with prior approval.

Important Fees

Returned/bounced checks: $30 **Appointments Cancelled without 24 hours advanced notice: $50**

Please help us serve you better by keeping all scheduled appointments or by notifying us 24 hours prior to your appointment. **In case of emergencies, please contact our office.**

I, the patient mentioned above, authorize the release of any information necessary to determine liability for payment and to obtain reimbursement or request that payment of authorized benefits to made on my behalf.

We must emphasize that as health care providers we are dedicated to provide the best treatment for our patients. **We will do our best in the filing of insurance claims, however if your insurance fails to pay, all charges are your responsibility from the date services are rendered.**

Thank you for your cooperation and please let us know of any questions or concerns that you may have.

I, the undersigned, have had an 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 use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

I, the undersigned, have also read, understand and agreed to this authorization of dental benefits payments as well as to the office's financial policy.

Print Name: _____ **Signature:** _____
Date:____/____/_____

PLEASE UNDERSTAND THAT FAILURE TO SIGN THIS FORM MEANS THIS OFFICE CANNOT LEGALLY ACT AS YOUR DENTAL PROVIDER AND **WE WILL BE UNABLE TO TREAT YOU.**