**AMG FAMILY DENTISTRY**
Galina Goldenberg DDS
314 Ernston Road
Parlin, NJ 08859
Phone: (732) 721-3311 · Fax: (732) 721-3543

## PATIENT INFORMATION

Today's Date: ___________ Email: ___________________________________Birthdate: ____/____/____Age: _______

Name: ____________________________________________ I prefer to be called: _________________ ◻ Male ◻ Female
Last First MI

Home Phone: _____________________Cell Phone: __________________ Business Phone: ________________________

Driver's License #: _________________________________Occupation: _______________________________________

SS#:_________________ ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻ Separated Employer: ______________________

Home Address: ___________________________________ Employers Address: ________________________________

________________________________________________ _________________________________________________
City State Zip City State Zip

Spouse/Parent/Guardian Name: ________________________ Birthdate: ____/____/____Occupation: _______________

Primary Phone: ____________________Work Phone: _______________________ Employer: _____________________

Where & when are best times to reach you? ______________ Whom may we thank for referring you? _________________

In the event of an emergency, who should be notified? _____________________________Phone: ____________________

## PRIMARY DENTAL INSURANCE

Person Responsible for Account: ________________________________ Relationship to Patient: _____________________

Birthdate: ______________ SS #: ____________________ Home Phone: _______________Cell Phone: ______________

Billing Address: _________________________________ Employer: ___________________________________________

_______________________________________________ Business Phone: _____________________________________

Primary Insurance Co. Name: ________________________________ Insurance Co. Phone: ________________________

Insurance Co. Address: ________________________________________________________________________________

Subscriber ID #: _____________________________________________Group/Policy #: _________________________

## SECONDARY DENTAL INSURANCE (if applicable)

Insured Name: _______________________________________ Relationship to Patient: ____________________________

Birthdate: ______________ SS #: ___________________ Home Phone: _______________Cell Phone: ______________

Billing Address: _________________________________ Employer: ___________________________________________

_______________________________________________ Business Phone: _____________________________________

Primary Insurance Co. Name: ________________________________ Insurance Co. Phone: ________________________

Insurance Co. Address ________________________________________________________________________________

Subscriber ID #: __________________________________________ Group/Policy #: ____________________________

## DENTAL HISTORY

Reason for Today's Visit: ______________________________

Former Dentist: ______________________ Date of Last X-Rays: ______________

City, State: ______________________ How Often Do You Floss? ______________

Date of Last Dental Visit: ______________________ How Often Do you Brush? ______________

**Please Check All That Apply:**

- Bad Breath…………………. ☐
- Bleeding Gums…………….. ☐
- Blisters on Lips or Mouth….. ☐
- Finger Nail Biting………….. ☐
- Grinding Teeth…………….. ☐
- Lip or Cheek Biting………… ☐
- Loose Teeth or Broken Fillings…… ☐
- Orthodontic Treatment…………… ☐
- Pain around Ear………………….. ☐
- Periodontal Treatment…………… ☐
- Sensitivity to Cold………………. ☐
- Sensitivity to Hot……………….. ☐
- Sensitivity to Sweets…………………. ☐
- Sensitivity When Biting……………… ☐
- Frequent Headaches…………………. ☐
- Jaw, Head or Neck Injuries………….. ☐
- Jaw Difficulty; Clicking and/or Pain…. ☐
- Tooth Pain……………………………. ☐

## MEDICAL HISTORY

Physician's Name: ______________________________ Date of Last Visit: ______________

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment?……………… | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations?…. | ☐ | ☐ |
| 3. Do you smoke?…………………………………………… | ☐ | ☐ |
| 4. Do you use alcohol?……………………………………… | ☐ | ☐ |
| 5. Do you wear contact lenses?……………………………… | ☐ | ☐ |
| 6. Are you currently taking any medications?……………… | ☐ | ☐ |

Please List **Medications**: ______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

7. Have you had any **allergic** reactions to the following?

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. Novocain)………….. | ☐ | ☐ |
| Penicillin…………………………………… | ☐ | ☐ |
| Sulfa……………………………………….. | ☐ | ☐ |
| Barbiturates (sleeping pills)………………. | ☐ | ☐ |
| Sedatives…………………………………. | ☐ | ☐ |
| Aspirin……………………………………. | ☐ | ☐ |
| Iodine…………………………………….. | ☐ | ☐ |
| Other……………………………………… | ☐ | ☐ |

8. **(Women Only)** Are You:

| | Yes | No |
|---|---|---|
| Pregnant?………………………………… | ☐ | ☐ |
| Nursing?…………………………………. | ☐ | ☐ |
| Taking Birth Control Pills?……………… | ☐ | ☐ |

**Please check all that apply:**

- AIDS……………………………. ☐
- Anemia…………………………. ☐
- Arthritis, Rheumatism…………. ☐
- Artificial Heart Valves…………. ☐
- Artificial Joints………………… ☐
- Back Problems………………… ☐
- Abnormal Bleeding w/Surgery….. ☐
- Blood Disease…………………. ☐
- Cancer…………………………. ☐
- Chemical Dependency…………. ☐
- Chemotherapy…………………. ☐
- Chronic Fatigue Syndrome…….. ☐
- Circulatory Problems…………… ☐
- Congenital Heart Lesions………. ☐
- Cortisone Treatments……… ….. ☐
- Cough persistent/bloody………. ☐
- Diabetes……………………….. ☐
- Emphysema………………… ☐
- Epilepsy……………………. ☐
- Fainting or Dizziness……….. ☐
- Glaucoma…………………… ☐
- Headaches………………….. ☐
- Heart Murmur………………. ☐
- Heart Problems……………… ☐
- Hepatitis –Type___…………. ☐
- Herpes………………………. ☐
- High Blood Pressure………… ☐
- Low Blood Pressure…………. ☐
- Jaundice…………………….. ☐
- Swelling of Feet/Ankle……… ☐
- Latex Sensitivity……………. ☐
- Kidney Disease……………… ☐
- Liver Disease………………… ☐
- Mitral Valve Prolapse……….. ☐
- Anxiety……………………………. ☐
- Pacemaker………………………… ☐
- Psychiatric Care…………………. ☐
- Radiation Therapy………………. ☐
- Respiratory Disease……………… ☐
- Rheumatic Fever………………… ☐
- Scarlet Fever…………………….. ☐
- Shortness of Breath……………… ☐
- Sinus Trouble……………………. ☐
- Skin Rash………………………… ☐
- Stroke……………………………. ☐
- Thyroid Problems……………….. ☐
- Tonsillitis………………………… ☐
- Tuberculosis……………………… ☐
- Ulcer……………………………… ☐
- Venereal Disease………………… ☐
- HIV Positive…………………….. ☐

**I understand that the information that I have given today is correct to the best of my knowledge. I hereby authorize payment to AMG Family Dentistry for all insurance benefits otherwise payable to me fo services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the above doctor and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

Signature______________________ Date___/___/______ Dr's initials ______________

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# OFFICE POLICIES

**APPOINTMENTS:**

We confirm appointments as a courtesy. The appointments we make are set up just for you. If we are unable to confirm your appointment the day before, you are still liable for keeping your appointment. If there is a no show – no call within the 24 hour period a $75.00 fee will be charged for overhead expenses, $150.00 for Saturdays.

**FINANCIAL AGREEMENTS:**

Patient/guardian is responsible for all charges, whether or not paid by insurance company. Patients/guardians are responsible for all co-pays and deductibles as per agreement between the Doctor and insurance company. All co-pays and deductibles are due at time of visit.

If you are referred to a specialist, we are not responsible for their fees or co-payments. Insurance participation with the specialist cannot be guaranteed by us.

**RETURN CHECKS:** An assessment fee of $45.00 will be made for a returned check, plus a bank fee of $15.00 will also be assessed. A cash/credit card payment will be expected before another appointment can be scheduled.

**We reserve the right to transfer any outstanding accounts (90 days or more) to a collection agency, unless prior payment arrangements are made. Additional fees may apply.**

Print Name: ______________________________________________________

Signature: ____________________________________________ Date: / /

Relationship to patient (if signed by a personal representative of patient): ______________________________

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## INFORMED CONSENT

I hereby give my consent to advisable and necessary dental procedures and pharmacological agents to be administered or prescribed by *Dr. Galina Goldenberg* and / or her staff.

I also give my consent for necessary record making, such as medical and dental history, study models, x-rays, photographs or laboratory tests.

I understand that undesirable effects, although infrequent, may follow surgical or operative procedures upon the teeth, jaws and mouth. These effects include tooth sensitivity, infection, swelling, bleeding, discoloration, discomfort, numbness and fracture of the teeth, bony tissues and shrinkage gingival tissues.

I understand that during the course of treatment, procedures may need to be changed, added, or expanded. The most common include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges or implants.

Print Name: ______________________________________________________________

Signature: __________________________________________________ Date: / /

Relationship to patient (if signed by a personal representative of patient): ______________________________

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## Notice of Privacy Practices

## Patient Acknowledgement

I have read and understand the practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practice upon request.

Print Name: ____________________________________________

Signature: ______________________________________ Date: / /

Relationship to patient (if signed by a personal representative of patient):______________________