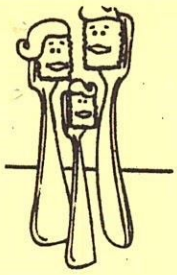

Dr. Hal Wolfson

Allwood Family Dentistry

46 Market Street
Clifton, New Jersey 07012
Tel: (973) 365-2265

OFFICE USE ONLY			
Date Completed			
Date Updated			

EMAIL-

Getting To Know You

Whom may we thank for referring you? _____

☐ Friend ☐ Relative ☐ Phonebook ☐ Dental Society ☐ Other

Patient Information (Please print and complete in full.)

MR / MRS / MS Patient's name		Marital Status S M W D Sep	Date of Birth	Sex M F	Social Security No.
Address (Apt.)	City	State	Zip Code	Home phone no.	CELL NO:
Patient's employer	Occupation (indicate if student)			How long employed?	
Employer's address	City	State	Zip Code	Business phone no. (ext.)	
Spouse's name	Date of birth	Social Security No.		No. of children	
Spouse's employer	Occupation (indicate if student)			How long employed	
Employer's address	City	State	Zip Code	Business phone no. (ext.)	

Responsible Party - If not patient

Person responsible for payment	Address	City	State	Zip Code
Relationship to patient	Social Security No.	Home phone no.		
Employer	Occupation	How long employed?		
Employer's address	City	State	Zip Code	Business phone no. (ext.)
Method of payment ☐ cash ☐ check	☐ Credit Card	☐ Visa no._____ ☐ MasterCard no._____		
If patient is a minor or student School	Address	City	State	Zip Code

Insurance Information: List below any insurance policies that may cover any part of our services.

Name of policy holder	Policy holders date of birth	Policy holders Social Security No.
Insurance Company	Policy no.	Group no.
Insurance company address		Phone no.

Practice Policy: It is the policy of this practice that fees be paid at the time services are rendered. We feel that regular visits and preventive treatment are the best protection against long and costly procedures. However, when the cost of necessary treatment exceeds your budget, we have various payment plan options which must be arranged in advance of treatment. In the event that payment becomes default and that this account is given to an attorney or agent for collection, I agree to pay any additional fees incurred.

Responsible party signature _____ Date _____

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No	COVID-19	○ Yes ○ No				

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

46 Market Street
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Allwood Family Dentistry, PA

Dr. Hal Wolfson

FINANCIAL ARRANGEMENT AND DENTAL INSURANCE

Thank you for choosing Allwood Family Dentistry for your dental care. We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. If you choose, we will gladly accept payment for dental treatment directly from your insurance company. In order to achieve these goals, we need your assistance and understanding of our payment policy.

1. Payment for services is due at the time of service, unless prior arrangements have been made with our staff. We accept cash, checks, Master Card, Visa or Amex. We will be happy to help you process your insurance claim form, however, any deductible or co-payments are due at the time services are rendered

2. You agree to pay your bill in full if your insurance company has not paid within 90 days of your treatment. We agree to process your claims in a timely fashion to avoid such problems. We also agree to provide your insurance company with any information they need to process your claim.

3. If you do not wish to leave a credit card on file, we will require that you pay for treatment in full at the time of service. We will provide you with the required information so you may submit for reimbursement from your insurance company.

4. Returned checks and balances older than 30 days will be subject to an interest charge of 1.5% per month. If your account is turned over to an attorney for collection, you will be responsible for 33.33% legal fees and all court costs. A $75 charge will be made for broken appointments and for appointments canceled without a 24-hour advance notice.

5. Another option available is a dental credit card such as Care Credit. Once you are approved, we will be paid at the time of treatment and you can pay your bill on a monthly basis.

We must emphasize that our relationship is with you and not with your insurance company. Filing the claims is a courtesy we extend to our patients. However, all charges are your responsibility. You agree that we are not ultimately responsible for various services that your insurance company may not cover. You are responsible for knowing your benefits and informing us of any changes. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Credit Card Authorization

I authorize Allwood Family Dentistry to charge my credit card any balance that is outstanding after the insurance payments are made or 90 days from the date of service, whichever shall come first. I extend this authorization for the account of my spouse and/or dependents.

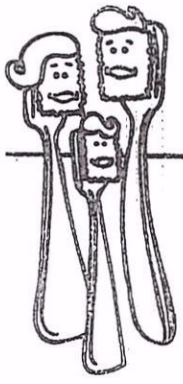
Card Holder's Name_____ Patient(s) Name_____

Credit Card Type _____ Card # _____

Exp. Date _____Code #_____ Signature_____

I understand that the fees I incur at Allwood Family Dentistry are ultimately my responsibility regardless of whether or not my insurance covers my treatment. I have read all the information on this sheet. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status, insurance coverage or the above information.

Signature (Parent if Minor) _____ **Date** _____



Allwood Family Dentistry, LLC

Dr. Hal Wolfson
46 Market Street
Clifton, New Jersey 07012
Tel.: (973) 365-2265

Appointment Policy

Your Time is Valuable and so is Ours

Please understand that there is a method to our scheduling of appointments. We are available for extended hours so that you can make appointments when it is convenient for you. When we book appointments for you, you book our time, facilities, and attention. Every effort is made to keep on schedule so that no one is "rushed". Please understand that emergencies are beyond our control. In good faith, we respectfully ask patients to be prompt and to keep their appointments.

Our standard office policy regarding appointments is as follows:

1. We try to remind patients by telephone prior to the appointment, but understand that this is just a "courtesy call".
2. If we are unable to contact you, your appointment card (or appointment made over the phone) should adequately serve as your confirmation and implies your obligation to be present at the correct time.
3. If you need to change an appointment, we request at least 24 hours notice to avoid a charge for "LOST" time.
4. Exceptions to this policy can be determined only on an individual basis according to circumstances.

Charges for "LOST TIME" include not showing up at all, no telephone call, and/or cancellation of the appointment without 24 hours notice. There will be a $75.00 charge per occurrence.

I have read the above office policy and understand my obligations when an appointment is made with Allwood Family Dentistry. I understand that this cost is not covered by insurance.

Name and Date: _____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,_____have reviewed a copy of this Office's Notice of Privacy Practices.

_____

Print patients name if signing for minor

_____

Signature

Date _____

Is there any one you do not wish to receive medical information regarding this patient?
If yes – name of person_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

_____ Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

Other _____