STUART E. ALEXANDER, D.M.D.

19 North Main Street
Cranbury, NJ 08512

Phone: 609-395-8383
Fax: 609-395-1133

PATIENT INFORMATION

(COMPLETED BY PARENT FOR CHILD)

In order to ensure that we have accurate patient information, please take a moment and complete the following form for your child. Please be sure to notify us of any changes or corrections to his/her contact information and insurance status. This information shall remain confidential in accordance to our Notice of Privacy Practices. Thank you!

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ____

Nickname (if any): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Home Phone: _____

Current School (if applicable): _____

Sex: ☐ Male ☐ Female Birthdate: _____

PARENT / RESPONSIBLE PARTY INFORMATION:

Mother's Name: _____ Mother's SS# (for insurance): _____

Mother's Employer: _____ Phone: _____

Father's Name: _____ Father's SS# (for insurance): _____

Father's Employer: _____ Phone: _____

Who referred you to Dr. Alexander? _____

INSURANCE INFORMATION (BIRTHDAY RULE):

Primary Dental Carrier: _____

Subscriber's Name: _____

Subscriber's Birthdate: _____ Group #: _____

Secondary Dental Carrier (if applicable): _____

Subscriber's Name: _____

Subscriber's Birthdate: _____ Group #: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to Patient: _____ Phone: _____

_____ _____

PARENT'S SIGNATURE **TODAY'S DATE**

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Name: _____ Birthdate: _____/_____/_____

I have received this 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 and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required, by law, to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited or materially limited by law
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relations to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction
    - The right to received confidential communications of protected health information
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____/_____/_____

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

STUART E. ALEXANDER, D.M.D. ☐**PRIMARY** ☐**SECONDARY**

AUTHORIZATION FOR SIGNATURE ON FILE

19 North Main Street
Cranbury, NJ 08512

Phone: 609-395-8383

RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY / AUTHORIZATION FOR PAYMENT

I, _____ and/or _____
Name of Patient (Parent or Guardian if Minor) Name of Insured

hereby authorize the office of Stuart E. Alexander, D.M.D. to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____.
Current Employer

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR) **TODAY'S DATE**

_____ _____

SIGNATURE OF INSURED (IF DIFFERENT FROM ABOVE) **EXPIRATION DATE** (1 YEAR FROM TODAY'S DATE)

DENTAL HEALTH HISTORY

(Confidential)

Chart Color
☐ **RED** ☐ **GREY**
(For office use only)

Patient: _____ **Birthdate:** _____

Reason for Today's Visit: _____

Dental History

Former Dentist: _____ **Address:** _____

Date of Last Dental Care: _____ **Phone Number:** _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking / popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in mouth

How often do you brush? _____ **Do you floss?** _____ **Do you use a water pick?** _____

Medical History

Primary Physician's Name: _____ **Date of Last Visit:** _____/_____/_____

Have you ever been hospitalized? ☐YES ☐NO **If yes, most recent date:** _____/_____/_____

Have you ever had a blood transfusion? ☐YES ☐NO **If yes, give date(s):** _____/_____/_____

WOMEN ONLY: **Are you pregnant?** ☐YES ☐NO **Nursing?** ☐YES ☐NO **Taking birth control pills?** ☐YES ☐NO

CHECK (✓) IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ AIDS	☐ COUGHING UP BLOOD	☐ HIGH CHOLESTEROL	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ DIABETES	☐ HIV POSITIVE	☐ RHEUMATIC FEVER
☐ ARTHRITIS/RHEUMATISM	☐ DEMENTIA	☐ JAW PAIN	☐ SCARLET FEVER
☐ ARTIFICIAL HEART VALVES	☐ EATING DISORDER	☐ KIDNEY PROBLEMS/DISEASE	☐ SHORTNESS OF BREATH
☐ ARTIFICIAL JOINTS	☐ EPILEPSY/SEIZURES	☐ LIVER DISEASE	☐ STROKE
☐ ASTHMA	☐ FAINTING SPELLS/DIZZINESS	☐ LOW BLOOD PRESSURE	☐ STOMACH/INTESTINAL PROBLEMS
☐ BLOOD DISEASE	☐ GLAUCOMA	☐ LUNG DISEASE	☐ SWELLING OF FEET OR ANKLES
☐ CANCER	☐ CHRONIC HEADACHES	☐ MITRAL VALVE PROLAPSE	☐ THYROID PROBLEMS
☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ NERVOUS/ANXIETY PROBLEMS	☐ TOBACCO HABIT
☐ CHEMOTHERAPY	☐ HEART ATTACK/FAILURE	☐ ORGAN TRANSPLANT	☐ TONSILITIS
☐ CIRCULATORY PROBLEMS	☐ HEART PROBLEM/DISEASE	☐ PACEMAKER	☐ TUBERCULOSIS
☐ COLD SORES	☐ HERPES	☐ PARATHYROID PROBLEM/DISEASE	☐ TUMORS/GROWTHS
☐ CORTISONE TREATMENTS	☐ HEPATITIS	☐ PSYCHIATRIC CARE/MENTAL DISORDER	☐ ULCER
☐ CHRONIC COUGHING	☐ HIGH BLOOD PRESSURE	☐ RADIATION TREATMENT	☐ OTHER _____

Have you ever been pre-medicated for a previous dental treatment? ☐YES ☐NO

_____

_____

Pharmacy Name: _____
Address: _____
Phone Number: _____

☐ **Aspirin**	☐ **Penicillin**
☐ **Antibiotics**	☐ **Latex**
☐ **Codeine**	☐ **Local Anesthetic**
☐ **Sulfa**	☐ **Other:** _____

☐ **NONE**

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ *Date:* _____

Stuart E. Alexander, 19 North Main Street, Cranbury, NJ 08512 609-395-8383