South Jersey Center for Dental Medicine
JOSEPH A. SANDBERG D.M.D.

PATIENT INFORMATION

First Name _____ MI___ Last Name_____ Birthday _____
Social Security Number _____ Address _____ City _____
State _____ Zip Code _____ E-mail _____ Cell Phone _____
Home Phone _____
Circle One: Minor Single Married Divorced Widowed Separated
Emergency Contact Name _____ Emergency Contact Phone Number _____

EMPLOYER INFORMATION

Employer _____ Employer Address _____
City _____ State _____ Zip Code _____ Phone Number _____

INSURANCE INFORMATION

Primary Insurance Company_____ Group Number _____ ID Number _____
Please complete below if subscriber is not you:
Subscriber's Full Name _____ Employer _____ Birthday _____
Social Security Number _____ Relationship To Patient: Spouse Parent Other_____
Secondary:
Insurance Company_____ Group Number _____ ID Number _____
Please Complete Below If Subscriber Is Not You:
Subscriber's Full Name _____ Employer _____ Birthday _____
Social Security Number _____ Relationship To Patient: Spouse Parent Other_____

MEDICAL HISTORY

Physician: _____ Office Phone Number _____ Date Of Last Exam: _____
1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medication(s), including non-prescription medicine? Yes No
If yes, please list medication(s):_____
_____.
4. Do you smoke? If yes: What do you smoke and for how long have you been smoking?_____
5. Do you drink alcohol? If yes: How frequently?_____
6. Do you use any other drugs? If so please specify: _____
7. Have you tested positive for COVID-19? Yes No
8. Circle any allergies: Local Anesthetic Penicillin Or Other Antibiotics Latex Aspirin Nickel None
Other:_____
9. Women Only: Are you pregnant or think you may be pregnant? Yes No
10. Are you nursing? Yes No
11. Are you taking birth control pills? Yes No
12. Address of preferred pharmacy: _____

13. Circle any prior or current conditions:

High Blood Pressure	Heart Attack	Rheumatic Fever	Swollen Ankles	Seizures
Asthma	Liver Disease	Epilepsy/Convulsions	Leukemia	Diabetes
Kidney Disease	AIDS or HIV Infection	Thyroid Problem	Heart Disease	Ulcers
Heart Murmur	Angina	Frequently Tired	Anemia	Emphysema
Cancer	Arthritis	Joint Replacement	Stomach Problems	Hepatitis/Jaundice
Chest pains	Easily Winded	Stroke	Hay fever/Allergies	Tuberculosis
Radiation Therapy	Glaucoma	Recent Weight Loss	Low Blood Pressure/ Fainting	Cardiac Pacemaker/ Valve Replacement
Respiratory Problems	Sexually Transmitted Disease			

Other:_____

_____

PATIENT DENTAL HISTORY

1. Teeth sensitive to: Cold Hot Sweet Sour No sensitivity
2. Circle any of the following problems pertaining to your jaw:
   Clicking Pain Difficulty Opening/Closing Difficulty Chewing None
3. Do your gums bleed while brushing or flossing?
4. Do you have any dental pain?
5. Do you have any sores or lumps in or near your mouth?
6. Do you have any history of head, neck or jaw injuries?
7. Do you have frequent headaches?
8. Do you clench or grind your teeth?
9. Have you had prolonged bleeding after an extraction?
10. Have you had orthodontic treatment done?
11. I think the present state of my teeth is: Very Healthy Some Disease/Decay In Poor State
12. Improving the health of my mouth is: High Priority Medium Priority Low Priority
13. Improving the appearance of my smile is: High Priority Medium Priority Low Priority
14. In the past, I have gone to the dentist: Regularly Occasionally For Emergency Care Only

SIGNATURE

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

X _____ _____

Signature Date

Joseph A. Sandberg, D.M.D.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this NOTICE while it is in effect. This NOTICE took effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this NOTICE at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our NOTICE effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the NOTICE and make the new NOTICE available upon request.

You may request a copy of our NOTICE at any time. For more information about our privacy practices, or for additional copies of this NOTICE, please contact us using the information listed at the end of this NOTICE.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this NOTICE.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this NOTICE. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you requested unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). We will charge you a reasonable cost-based fee for expenses such as copy your health information and staff time. You may also request access by sending us a letter to the office. If you request copies, we will charge you $1.00 per page, $ __ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

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 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) 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 written form.

Joseph A. Sandberg, DMD, MAGD

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Marlton, NJ 08053

856-596-4333

Sandbergdentistry@gmail.com

South Jersey Center for Dental Medicine
JOSEPH A. SANDBERG D.M.D.

AKNOWLEDGEMENT OF RECEIPT OF: "NOTICE OF PRIVACY PRACTICES"

** You may refuse to sign this acknowledgement **

"Notice Of Privacy Practices" for this office was made available to me.

I have read and understood the Notice.

Print Name: _____

Signature: _____

Date: _____

South Jersey Center for Dental Medicine
JOSEPH A. SANDBERG D.M.D.

DENTAL PATIENT FINANCIAL AGREEMENT

We are happy to complete and submit your insurance claims for you dental care.

No guarantees or promises can be made about which procedures will be covered by your insurance.

We do our best to estimate your co-payment but it is based on limited information provided by your insurance company.

In most cases, we will accept assignment but do require payment of the estimated co-payment and deductible at the time of service.

I understand and accept full financial responsibility for all services provided regardless of insurance coverage.

FAQ'S ABOUT DENTAL INSURANCE

1. Do you know how much my insurance will pay?

We do our best to estimate what portion may be covered by your insurance company but due to limited information they provide, actual amounts cannot be determined. maximum allowable charges, waiting periods, and frequency limitations can effect benefits.

2. How can I find out what my insurance covers?

General terms can be found in your insurance policy manual, website portal, or. from your human resources department at work. Be sure to ask how frequently services can be rendered (I.e. cleanings, x-rays, crowns) and if there are any waiting periods.

3. Do I need a predetermination?

No. A predetermination is not required for treatment to begin. It will however help determine if a procedure is covered and how much will be paid by the insurance company. It can often take 4 to 6 weeks to receive the pre-determination from your insurance company, and it will still state that payment is not guaranteed.

4. How do I best take advantage of my insurance benefits?

We can estimate your payment based on the average plan and will accept payment directly from the insurance company if your company will allow for that. You will need to pay your estimated copayment and any deductibles at the time of service, as well as any difference between the estimated and actual amounts after your insurance has made their payment. If the insurance does not pay for a procedure, full payment is required by you.

Print Name: _____

Signature: _____

Date: _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____ YES	_____ NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

IF SO, WHERE? _____

South Jersey Center for Dental Medicine
JOSEPH A. SANDBERG D.M.D.

DENTAL RECORDS RELEASE AUTHORIZATION

I authorize the release of my dental records to South Jersey Center for Dental Medicine. Please fax, e-mail or mail any recent radiographs and pertinent clinical notes to:

Fax: (856) 596-1726

E-mail: sandbergdentistry@gmail.com

Mailing Address: 525 Route 73 South, Suite 105

Marlton, NJ 08053

Thank you very much,

Print Name: _____

Signature: _____

Date: _____