CHURCH STREET
Family & Cosmetic Dentistry

Welcome To Our Practice

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home ( ) _____ Cell ( ) _____

Name _____ SS# _____-_____-_____
Last Name First Name Middle Int.

Address _____ Email _____

City _____ State _____ Zip Code _____

Sex ☐ Male ☐ Female Birthday _____ ☐ Married ☐ Widowed ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School _____ Occupation _____ Full Time Student ☐ Yes ☐ No

Employer/School Address _____ Employer/School Phone ( ) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone ( ) _____

Primary Insurance

Person Responsible for Account? _____
Last Name First Name Middle Int.

Relationship to Patient _____ Birthday _____ SS# _____-_____-_____

Address (if different from patients) _____ Phone ( ) _____

City _____ State _____ Zip Code _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Insurance Company Name _____

Contact # ( ) _____ Group # _____ Subscriber # _____

Name of other Dependants under Plan _____

Additional Insurance

Is patient covered by additional Insurance ☐ Yes ☐ No

Subscriber Name _____ Birthday _____ Relation to Patient _____

Phone ( ) _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Insurance Company Name _____

Contact # ( ) _____ Group # _____ Subscriber # _____

Name of other Dependants under Plan _____

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Health Information

Have you ever had any of the following?

Y or N AIDS/HIV
Y or N Allergies_____
_____
Y or N Anemia
Y or N Arthritis
Y or N Art. Joint/Organ
Y or N Aspirin Therapy
Y or N Asthma
Y or N Blood Disease
Y or N Blood Thinners
Y or N Cancer
Y or N Diabetes
Y or N Dizziness
Y or N Epilepsy
Y or N Excess Bleeding
Y or N Fainting
Y or N Glaucoma
Y or N Hay Fever
Y or N Head Injuries
Y or N Heart Disease
Y or N Heart Murmur
Y or N Hepatitis
Y or N High Blood Pressure
Y or N High Cholesterol
Y or N Jaundice
Y or N Kidney Disease
Y or N Liver Disease
Y or N Mental Disorders
Y or N Mitral Valve Prolapse
Y or N Nervous Disorders
Y or N Pace Maker
Y or N Radiation Treatment
Y or N Respiratory Problems
Y or N Rheumatic Fever
Y or N Rheumatism
Y or N Sinus Problems
Y or N Stomach Problems
Y or N Stroke
Y or N Thyroid
Y or N Tuberculosis
Y or N Tumors
Y or N Ulcers
Y or N Venereal Disease

- Are you allergic to any of the following: Penicillin ☐ Codeine ☐ **LATEX** ☐
- Are you currently under the care of a physician? Yes ☐ No ☐ Please explain:_____
  Name of Physician:_____ Phone Number:_____
- Are you currently taking any medication? Yes ☐ No ☐ Please list:_____
- Are you currently pregnant? Yes ☐ No ☐ Due Date: _____
- Do you smoke? Yes ☐ No ☐ How often?_____
- Have you ever had any complications following dental treatment? Yes ☐ No ☐
  If yes, please explain:_____
- Would you like to have **Whiter Teeth**? Yes ☐ No ☐
- Rate your dental health 1(worst) – 10 (best)_____ How can we make this better for you?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Financial Disclosure/Consent for Services

Please be advised that the clinical team (Doctors and Hygienists) does not allow any patient's oral health to be influenced by their insurance company. Church Street Family and Cosmetic Dentistry will do their best at estimating any co-insurance that may be due from you for any necessary treatment and will be collected the day services are rendered (unless other arrangements have been made with the front staff). In New Jersey, insurance companies are required by law to settle claims within 30 days. Our office sends out claims the day after services are rendered. If your insurance company does not pay your claim in 45 days, you will be personally responsible (you may negotiate with your insurance company). Note that if there is an overpayment made by you, the office will submit a refund once the insurance company has paid.

Our practice accepts all major credit cards, cash, check and/or Care Credit.
Should you have any questions about our financial policy, feel free to ask the front desk.
I have read and understood the above financial/consent for services disclosure.

_____
Patient, Parent/Guardian Signature Date

Financial Policy

PATIENTS WITH INSURANCE COVERAGE

We will be glad to help you obtain the appropriate benefit from your insurnace carrier and bill your carrier as a courtesty to you. **However, you are responsible for the payments of the acount.**

We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. **Sometimes there is a co-payment and/or deductible required by you as per your insurance agreement.** Even if you have secondary coverage (this is possible if you and your spouse both have insurnace), there may still be a portion that will be your responsibility.

PATIENTS WITHOUT INSURANCE COVEREAGE

Patients without insurance coverage are requested to pay for services as rendered. We accept cash, checks, MasterCard, Visa, American Express and Discover payments.

ADDITIONAL TERMS

Appointments that are cancelled with less than 48 hours notice which includes same day or no call/no show are subject to a $50.00 charge. Checks returned by your bank are subject to a $35.00 processing charge. Accounts unpaid after 45 days from the date of billing are subject to a $5.00 monthly fee. If your account is referred for collection, you will be responsible for collection costs together with court costs and reasonable attorney's fees.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF CHURCH STREET FAMILY AND COSMETIC DENTISTRY, DR. VENETIA ZERVOS AND DR. SHANNI REINE-MUTCH.

_____

Signature of Patient of Guardian Date

CHURCH STREET
Family & Cosmetic Dentistry

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 REVIEW IT 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 takes 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 this 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 to 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 or 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 request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $0.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 a 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 to 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 (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Venetia Zervos, D.D.S.

Telephone: 856-778-2700 Fax: 856-778-2227

E-mail: DrZervos@aol.com

Address: 817 S. Church Street, Mt. Laurel, NJ 08054

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

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 (Please Specify)

_____

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