LINDENWOLD DENTAL CENTER

Dr. Ishak Said, D.M.D. • Dr. Joel Okon, D.D.S.

254 Gibbsboro Road • Lindenwold, NJ 08021
Tel: (856) 783-3777 • Fax: (856) 783-6891

PATIENT INFORMATION

We are pleased to welcome you to our office. 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.

PERSONAL

Name: ____________ ____________ ____ ____________
Last First MI (Preferred)

Birthdate: ____________ SS #: ____________ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: ____________ Wireless Phone: ____________

Email: ____________

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) ☐ Non Student ☐ Full Time ☐ Part Time

How did you hear about us? ☐ Google ☐ Facebook ☐ Friend/family (list below person's name) ☐ other (list below)

____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: ____________

Address 2: ____________

City: ____________ State: ______ Zip: ____________

Home Phone: ____________

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: ____________ Subscriber ID #: ____________

Insurance Company: ____________ Phone: ____________

Employer: ____________ Group Name: ____________ Group #: ____________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: ____________ Subscriber ID #: ____________

Insurance Company: ____________ Phone: ____________

Employer: ____________ Group Name: ____________ Group #: ____________

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Medical History

Last Name: ____ First Name: ____ Birthdate: ____
Name of Medical Doctor: ____ City/State: ____
Emergency Contact ____ Phone ____ Relationship ____

Mark any medications that you are no longer taking and add any new ones:

- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____
- [ ] ____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Problem
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

Tobacco use? If so, what kind and how much? ____
Unusual reaction to dental injections? ____
Reason for today's visit ____ Are you in pain? ____
New patients:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ____
Do you have BiteWing x-rays that are less than 1 year old? ____
Name of former dentist ____ City/State ____
Date of last cleaning and exam ____

Date: ____

Patient Signature: ____

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Financial Agreement

Last Name: ____________ First Name: ____________ Birthdate: ____________

Date: 1/8/2024

We are committed to providing you with the best care possible and welcome your comments and suggestions. If you have insurance, we are eager to help you receive the maximum benefits allowed. To achieve those goals, we need you to understand our payment policy. We appreciate you taking the time to read and understand the policies below.

Uninsured patients:

Payment is due at the time services are provided. For your convenience, payment can be made with cash, any major card, Apple Pay, and Venmo. If your treatment extends over a period of time, we expect payment to be made during the course of treatment.

Insured patients:

As healthcare providers, our relationship is with you, not your insurance company.

Estimated coinsurance is due at the time services are rendered. We will be happy to discuss your proposed treatment and answer any questions related to your insurance to the best of our ability, however:

1.) Your insurance is a contract between you, the insurance company, and your employer. We are not part of that contract. Filing insurance claims is a courtesy we provide.
2.) Our rates are considered to be within the acceptable range of most insurance companies.
3.) Not all services are covered benefits in all contracts.
4.) Our estimate of insurance coverage is only an estimate based on the information available to us.
We know that temporary financial problems can affect timely payment of your bill. If such issues arise, please contact us immediately for assistance in managing your account.

Our policy for MISSED/Cancelled/Rescheduled appointments within 24 hours.
There is a fee of $50 for any appointment with the doctor and $25 for the hygenist. WE REQUIRE 24 HOUR notice for cancellations/rescheduling. If the patient misses an appointment without proper notification, another patient will lose that time.

Any/all checks we receive that are RETURNED from the bank are subject to a fee ranging from $25 to $50, as this depends on the banking institute and not us.

In the event this agreement becomes a collections matter, the patient/guarantor will be responsible for all charges and costs related to collection activities.

I have read and understand the above policies.

I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes

☐ No

____
Patient Signature

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Lindenwold Dental Center
254 E Gibbsboro Rd. Lindenwold NJ 08021

I understand that, under th Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name________________________________

Relationship to Patient____________________________

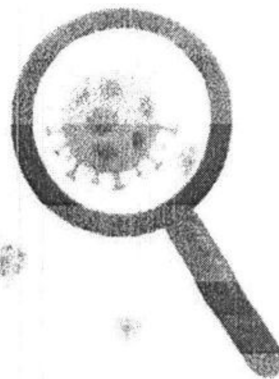
Signature:__________________________________

Date____________________________________

office use only

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

date: Initals: Reason:



DR.ISHAK SAID, DMD
254 GIBBSBORO RD.
LINDENWOLD, NJ 08021

I,______________________________, agree to answer the following questions regarding my treatment with our office during the Covid-19 pandemic.

1. Have you been tested for Coronavirus? Yes No
2. Did you test positive for the virus? Yes. No
3. What was the date of test , if tested?________
4. Have you experienced fever, chills, headache, nausea, or vomiting (within the past 14 days? Yes. No
5. Have you traveled outside the state or US? Yes. No.
   (if you have ,then when did you return?) _________
6. Have you been in contact with anyone who has tested positive for. Covid-19. If so when?______________. Yes. No
7. Have you been in contact with anyone who has been out of the Country? If so, when?______________. Yes. No
8. Weakness in any limbs? Yes. No

Any loss of taste or smell ? Yes. No

I HAVE ANSWERED EACH QUESTION HONESTLY AND TO THE BEST OF MY ABILITY. IF I ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, I UNDERSTAND THAT, FOR THE HEALTH OF MYSELF AND OTHERS, MY TREATMENT MAY BE POSTPONED FOR AT LEAST 14 DAYS FROM NOTED EXPOSURE OR PRESENT SCHEDULED APPT. PER CDC REGULATIONS AND PROVIDER RECOMMENDATIONS.

SIGNATURE:______________________________.

DATE:____________________________