Barclay Family Dental
75 Barclay Shopping Center
CHERRY HILL, NJ 08034

(856) 288-3708

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ¨ M ¨ F ¨ Married ¨ Widowed ¨ Single ¨ Minor

¨ Separated ¨ Divorced ¨ Partnered for _____ years

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Birthdate _____ Currently a patient in our office? ¨ Yes ¨ No

Employer _____ Work Phone _____

E-Mail _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (ü) if you have or 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 or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collecting between the teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever had any serious illnesses or operations?? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

¨ Anemia	¨ Congenital Heart lesions	¨ Hepititis	¨ Scarlet Fever
¨ Arthritis, Rheumatism	¨ Cortisone Treatments	¨ Hernia Repair	¨ Shortness of Breath
¨ Artificial Heart Valves	¨ Cough, Persistent	¨ High Blood Pressure	¨ Skin Rash
¨ Artificial Joints, Pins, etc.	¨ Cough up Blood	¨ HIV/AIDS	¨ Stroke
¨ Asthma	¨ Diabetes	¨ Jaw Pain	¨ Swelling of Feet or Ankles
¨ Back Problems	¨ Epilepsy	¨ Kidney Disease	¨ Thyroid Problems
¨ Bleeding Abnormally	¨ Fainting	¨ Liver Disease	¨ Tobacco Habit
¨ Blood Disease	¨ Glaucoma	¨ Mitral Valve Prolapse	¨ Tonsillitis
¨ Cancer	¨ Headaches	¨ Pacemaker	¨ Tuberculosis
¨ Chemical Dependency	¨ Heart Murmur	¨ Radiation Treatment	¨ Ulcer
¨ Chemotherapy	¨ Heart Problems	¨ Respiratory Disease	¨ Venereal Disease
¨ Circulatory Problems	¨ Hemophilia	¨ Rheumatic fever	¨

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

¨ Aspirin	¨ Local Anesthetic	¨ Iodine	¨ Other _____
¨ Barbiturates (Sleeping Pills)	¨ Penicillin	¨ Latex	_____
¨ Codeine	¨ Sulfa	¨ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Barclay Family Dental
75 Barclay Farms Shopping Center
Cherry Hill NJ, 08003
(856) 288-3708

Deposit & Cancellation Policy

When we book an appointment for you, we commit that time and our resources to your treatment. We make appointments with the expectation that you will attend at the agreed date & time to undergo your treatment. If you change your mind or work and other commitments prevent you from attending, we ask you to provide us with the required notice so that we can reallocate your appointment to another patient.

Please note that we will send text reminders a few days before your appointment that requires you to respond **YES** to automatically confirm your appointment. However, if you are not able to attend please call the office to reschedule.

If you are unable to make your appointment for any reason then you should inform us **no later than 48 HOURS** before your scheduled time. ***Note that weekends and holidays will not be included in this time frame.*** Failure to provide notice of a cancellation will result in the charge of a cancellation fee, which is determined by the length of time allocated to you, a **minimum of 25 dollars.**

For this reason, it is our policy, in certain cases, to request deposits and make a charge if insufficient notice of cancellation or amendment is given. When scheduling your appointment for treatment, we will seek a deposit from you, payment of which is your confirmation of your commitment to attend your appointment. Our deposits are normally fully refundable providing sufficient notice of cancellation is given, a minimum of 48 hours. .

For a family scheduling **3 or more family members** at the same appointment time we require a credit card to be put on your account in order to secure these appointments. A cancellation fee of **25 dollars per person** will **ONLY** be charged in the event that the required notice is not provided to cancel the appointments.

For any appointment that is **1 hour 30 minutes or longer** we require a deposit of **50 percent** of your estimated co pay. For **Zoom** appointments we require a deposit of **100** dollars.

We strive to see every patient as close to their appointment time as possible. However, this can only be achieved by **arriving on time for your appointment.** Please help us help you by arriving on time.

Name of Patient/Responsible Party Signature of Patient/Responsible Party Date

Doctor Signature Date

Barclay Family Dental

FINANCIAL AGREEMENT

Dear Patient:

Thank you for choosing Practice Name as your dental provider. The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures.

Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, Mastercard, Visa, Discover, and American Express. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that, whatever the insurance does not pay, is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE.**

You are responsible for knowing your insurance benefits. What are the covered services in your plan? Does your Dentist participate in the plan? Patients are responsible for deductible, co-insurance and non-covered amounts at the time of service. Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS and a PHOTO ID AVAILABLE FOR PHOTOCOPYING AT ALL TIMES**. Any change of insurance, address, phone number or emergency contact should be reported immediately.

Remember that insurance authorizations for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them, as charges will then be transferred to you. Interest on past due balances will accrue at a rate of 1.5 percent monthly. There will be a 25 dollar fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collections costs are calculated by adding to the principle the greater of 25 dollars, or an amount 35 percent in excess of the balance owed.

_____

Name of Patient/Responsible Party Signature of Patient/Responsible Party Date

_____

Doctor SIgnature Date

Barclay Family Dental, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices(NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communications
5. The right to a report of disclosures of your information
6. The right to a paper copy of this Notice.

We want to assure that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective date of this Notice: Effective as of date signed
Contact Person Kokila Punia DDS Phone Number 856-288-3708

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of the practice's ***NOTICE OF PRIVACY PRACTICES.*** I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified or changed in any way.

_____
Patient or Representative Name (please print)

_____ _____
Patient or Representative Signature Date

Patient refused to sign Patient was unable to sign because

_____