SUNITA MERRIMAN, DDS

GENERAL AND AESTHETIC ENHANCING DENTISTRY

IMPROVING THE LIVES OF OUR P ATIENTS

Date: ______________________

PATIENT INFORMATION

Name____ Birth date: ___________________________

Address: ____

Home phone: ___________________________ Work phone: ___________________________________

Cell phone: _______________________ E-mail address: ____

When is the best time of day to reach you? _____________________

Whom may we thank for referring you? ____

Are you: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Patient's/Parent's employer: ______________________________ _______________________________

Spouse's name: _________________________________ Spouse's employer: ______________________

Spouse's work number: ________________________ Spouse's cell phone: _____________________

In the event of an emergency, who should we contact (not living with you)? ________________

Relationship: ___________________

Home phone: _______________ Work phone:________________ Cell phone:_ __________________

RESPONSIBLE PARTY

Person responsible for this account: ___________________________ Relationship: ______________

Address: ____

Birth date: ________________ Employer: _______________________________________

Home phone: ______________ Work phone: __________________Cell phone:____________________

229 Charles Street Westfield, NJ 07090

Phone: 908.389.0222 Fax: 908.389.0223

www.DoctorMerriman.com Email: Info@doctormerriman.com

Is this person currently a patient in our office? ❑ Yes ❑ No

PRIMARY INSURANCE INFORMATION

Name of insured: ____________________________ Relationship: ________________________________

Insured's date of birth: ________________Social Security #: ____________________________________

Employer: ____ Work phone: __________________

Insurance company: _______ ____

Group # ____________________ ID#: ______________________________________ ____________________

Do you have any secondary insurance: ❑ Yes ❑ No
If yes, please complete the following:

Name of insured: ____________________________ Relationship: ________________________________

Insured's date of birth: ________________Social Security #: ____________________________________

Employer: ____ Work phone: __________________

Insurance company: _______ ____

Group # ____________________ ID#: ______________________________________ ____________________

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before their treatment begins. Please understand that payment of your bill is considered part of your treatment.

The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for all professional services rendered.

MISSED APPOINTMENTS:

Your health is our main objective. Therefore, it is extremely important for you to keep all your scheduled appointments. As a courtesy to other patients and our office we ask for as much notice as possible. If any appointment is canceled or failed without 48 hours' notice a fee of $60.00 will be charged. (We understand that emergency situations do arise that may require you to change an appointment and do not consider an occasional true emergency a missed appointment). After 2 consecutive missed appointments, it is our policy not to reschedule you for any further appointments without a discussion of what your health goals are and what your scheduling barriers may be. ***Please help us service you better by keeping scheduled appointments.***

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

We believe that our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such many routine, preventive and necessary dental services may not reimbursed even though you may need those services. We understand that insurance guidelines can be hard to understand and overwhelming at times. With the information provided to us by you and your insurance company, we can offer some assistance in estimating your insurance reimbursement. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. It is impossible for us to have knowledge and keep track of every aspect of your insurance. **It is ultimately your responsibility to know about the benefits available to you through the Insurance Company that your employer/spouse's employer/you have purchased.**

X-Rays:

If you have current x-rays from a previous dentist it is your responsibility to bring them to your initial appointment or have them transferred to our office. If you do not notify us that you have current films/digital x-rays we will take need to take new ones. Insurance companies have limitations on how often they will pay for x-rays. Therefore, it is important that you let us know if you have had recent ones taken.

PAYMENT:

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT PORTIONS and DEDUCTIBLES are due at the time of service. Any financial arrangements for your treatment must be made before the start of treatment.
Forms of payment available for your convenience are:

Cash or check

Visa, MasterCard, American Express

Third party financing (subject to approval)

After your claim has been filed with your insurance company, we will wait for a maximum of 40 days for the payment. If benefits have not been received within 40 days, the entire balance becomes your responsibility. A refund or an account credit (your choice) will be issued to you if any benefits are received from the insurance company after 40 days.

The office does not render services in the assumption that your charges will be paid by your insurance company.

We add a $10 billing charge for any statement sent 90 days after charges were incurred.

In the event of a returned check, you are responsible for all bank charges incurred by the office and an additional fee of $30.00.

Any unpaid balance over 60 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, you will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

I have read, understand and agree to the terms and conditions of this Financial Agreement. I have read and understand the above financial and office policy agreement. I have read and understand the Notice of Privacy Practice (HIPAA) posted in this office and will receive a copy of these upon my request.

____ ____________________

Patient name **Date**

____ ____________________

Patient/Legal Guardian Signature **Date**

229 Charles Street Westfield, NJ 07090

Phone: 908.389.0222 Fax: 908.389.0223

www.DoctorMerriman.com Email: Info@doctormerriman.com

CERTIFICATION AND ASSIGNMENT

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 minor child, ever have a change in health or insurance arrangements.

I certify that I, and/or my dependent(s), have insurance coverage with ____________________

(name of insurance company)

and assign benefits directly to Dr. Merriman's office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain valid until I revoke it in writing.

____ ____________________________

Signature of responsible party **Date**

____ ____________________________

Please print name of responsible party **Relationship to patient**

Date: ______________________

GENERAL CONSENT

I hereby voluntarily consent to dental examinations, treatments and/or procedures including x-rays, which are deemed necessary in the opinion of my dentist. I understand that above procedures may be performed by dentists, hygienists, and dental assistants. I understand that no guarantees or warranties have been made to me concerning the results of the examinations, treatments or procedures. I understand that successful treatment often depends upon my cooperation in following my doctor's instructions. I agree to fully follow my doctor's instructions and to fully cooperate in my care, including keeping any necessary additional appointments with my doctor, to enhance the possibility of successful treatment outcomes. I understand that Dr. Merriman is available to patients once treatment has begun when the office is open and is available for after-hours consultation or care in the event of an emergency.

Permission to Photograph

I authorize Dr. Merriman to take photographs and/or videos of my face, jaws, and teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications. I further understand that if the photographs and/or videos are used in any

publication, or as part of a demonstration, all reasonable attempts will be made to conceal my identity.

By signing below, I acknowledge that I have read this statement and agree to the contents.

____ _________________________

Signature of responsible party **Date**

____ _________________________

Please print name of responsible party **Relationship to patient**

AUTHORIZATION TO CONSENT FOR MINOR CHILD:
Signature of Person Authorized to Consent: ____
(Parent/Legal Guardian)

Print name and relationship to patient: ____

PATIENT MEDICAL HISTORY

Patient name: ____

Physician:___________________________ Office phone: _____________________________

Date of last exam: ____________________ Medical alert: ____________________________

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. Do you/have you in the past used cocaine and/or other drugs? ❑ Yes ❑ No
4. Do you wear contact lenses? ❑ Yes ❑ No
5. Are you taking any medication(s) including non-prescription medicine? ❑ Yes ❑ No
   If yes, what medication(s) are you taking? ____________________
6. Are you allergic to or have you had any reactions to the following:
   ❑ Local anesthetics ❑ Sulfa drugs ❑ Iodine
   ❑ Penicillin (or other antibiotics) ❑ Barbiturates ❑ Aspirin ❑Sedatives ❑ Other: ____________
7. **Women Only**: Are you pregnant or think you may be pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

8. Do you have **or** have you had any of the following?

❑ High blood pressure ❑ Heart murmur ❑ Easily winded
❑ Heart attack ❑ Angina ❑ Stroke
❑ Rheumatic fever ❑ Frequently tired ❑ Hay fever/allergies
❑ Swollen ankles ❑ Anemia ❑ Tuberculosis
❑ Fainting/seizures ❑ Emphysema ❑ Radiation therapy
❑ Asthma ❑ Cancer ❑ Glaucoma
❑ Low blood pressure ❑ Arthritis ❑ Recent weight loss
❑ Epilepsy/convulsions ❑ Joint replacement or ❑ Liver disease
❑ Leukemia implant ❑ Heart trouble
❑ Diabetes ❑Hepatitis/jaundice ❑ Respiratory problems
❑ Kidney disease ❑ Sexually transmitted ❑ Other ________________
❑ AIDS or HIV infection disease
❑ Thyroid problem ❑ Stomach
❑ Heart Disease troubles/ulcers
❑ Cardiac pacemaker ❑ Chest pains

Miscellaneous
____
____
____
____
_

None of the above conditions/No medical conditions______________ (please initial)

229 Charles Street Westfield, NJ 07090

Phone: 908.389.0222 Fax: 908.389.0223

www.DoctorMerriman.com Email: Info@doctormerriman.com

SUNITA MERRIMAN, DDS
GENERAL AND AESTHETIC ENHANCING DENTISTRY

IMPROVING THE LIVES OF OUR P ATIENTS

PATIENT SLEEP HISTORY

How many hours do you sleep every night? ______________________________________

What time do you go to bed? __________ What time do you wake up?_____________

Do you snore/wake up gasping for breath? ❑ Yes ❑ No

Does your bed partner snore/wake up gasping for breath? ❑Yes ❑ No

Do you wake up tired? ❑Yes ❑ No

Do you suffer from excessive daytime sleepiness? ❑Yes ❑ No

Have you been diagnosis with high blood pressure? ❑Yes ❑ No

Have you been diagnosis with GERD? ❑Yes ❑ No

Have you been diagnosis with obesity? ❑Yes ❑ No

Have you been diagnosis with diabetes? ❑Yes ❑ No

Have you been diagnosis with depression/mood disorder? ❑Yes ❑ No

Have you had a history of a stroke? ❑Yes ❑ No

Are you in any stage of menopause? ❑Yes ❑ No

Have you ever been diagnosed with a Sleep Disorder - Insomnia/Obstructive Sleep Apnea/Restless Leg Syndrome, etc. ? ❑Yes ❑ No

If so, what and when? ____

Do you grind/clench your teeth when sleeping or awake? ❑Yes ❑ No

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.

Signature: ____Date: ________________

Patient, parent or guardian

229 Charles Street Westfield, NJ 07090
Phone: 908.389.0222 Fax: 908.389.0223
www.DoctorMerriman.com email: Info@doctormerriman.com

SUNITAMERRIMAN,DDS

GENERAL AND AESTHETIC ENHANCING DENTISTRY

IMPROVING THE LIVES OF OUR P ATIENTS

Date: _______________

PATIENT DENTAL HISTORY & QUESTIONNAIRE

Patient name: ____

Date of last dental exam: _________________ Medical alert: ____________________________________

1. Are your teeth sensitive to hot or cold liquids/foods? ❑ Yes ❑ No
2. Are your teeth sensitive to sweet or sour liquids/foods? ❑ Yes ❑ No
3. Do you feel pain in any of your teeth? ❑ Yes ❑ No
4. Do you bite your lips or cheeks frequently? ❑ Yes ❑ No
5. Have you ever had any difficult extractions in the past? ❑ Yes ❑ No
6. Have you ever had prolonged bleeding following extractions? ❑ Yes ❑ No
7. Do you have trouble chewing your food? ❑ Yes ❑ No
8. Do you chew on one side of your mouth? ❑ Yes ❑ No
9. Do you have loose teeth or broken fillings? ❑ Yes ❑ No
10. Are you missing any teeth? ❑ Yes ❑ No
11. Are you a mouth breather? ❑ Yes ❑ No
12. Do you have any sores or lumps in or near your mouth? ❑ Yes ❑ No
13. Have you had any head, neck or jaw injuries? ❑ Yes ❑ No
14. Have you ever experienced any of the following problems in your jaw?
    - Clicking or popping? ❑ Yes ❑ No
    - Pain (joint, ear, side of face)? ❑Yes ❑ No
    - Difficulty in opening or closing? ❑ Yes ❑ No
    - Difficulty in chewing? ❑ Yes ❑ No
15. Have you noticed that your teeth have chipped/shifted in the past few years? ❑Yes ❑ No
16. Do you have frequent headaches? ❑ Yes ❑ No
17. Do you clench or grind your teeth? ❑ Yes ❑ No
18. Have you had any orthodontic work? ❑ Yes ❑ No
19. Do you wear any kind of retainer during the day/night? ❑ Yes ❑ No
20. Do you have bad breath? ❑ Yes ❑ No
21. Do your gums bleed while brushing or flossing? ❑ Yes ❑ No
22. Do you use a rotary toothbrush? ❑ Yes ❑ No
23. Have you ever had instruction on the correct method for brushing your teeth ❑ Yes ❑ No

229 Charles Street Westfield, NJ 07090

Phone: 908.389.0222 Fax: 908.389.0223

www.DoctorMerriman.com email: Info@doctormerriman.com

SUNITA MERRIMAN, DDS

GENERAL AND AESTHETIC ENHANCING DENTISTRY

IMPROVING THE LIVES OF OUR PATIENTS

24. Have you ever had periodontal treatment for:
    - Debridement/deep cleaning? ❑ Yes ❑ No
    - Periodontal/gum surgery? ❑ Yes ❑ No

25. Do you brush your teeth and gums too hard? ❑ Yes ❑ No
26. Do you enjoy smiling and showing your gums? ❑ Yes ❑ No
27. Are you happy with the way your teeth look? ❑ Yes ❑ No
28. How would you describe your smile?
    ❑ Great ❑ Average ❑ I don't smile much ❑ I never really thought about it

29. Are you pleased with the color of your teeth? ❑ Yes ❑ No
30. Have you ever whitened your teeth? ❑ Yes ❑ No
31. Do you have unsightly crowns or fillings? ❑ Yes ❑ No
32. Are your teeth too short or too long? ❑ Yes ❑ No
33. Are there any gaps between your teeth that you do not like? ❑ Yes ❑ No
34. Are you interested in cosmetic dentistry which may include Invisalign or Orthodontics (braces) as an option? ❑ Yes ❑ No
35. Is there anything about your smile that you would want to change if you could? ❑ Yes ❑ No

    Please describe: ____

36. Do you drink: ❑ Coffee ❑ Tea ❑ Red wine

    If yes, how much, and how often, per week? ____________________________

37. Do you currently smoke: Cigarettes? ❑ Yes ❑ No Cigars? ❑ Yes ❑ No

    If so, how many per day? ____________________

    How many years have you smoked? ____________

38. If you have quit smoking in the past, how many years did you smoke? __________
39. When did you quit and how much were you smoking per day then? ___________
40. Do you/have you in the past used cocaine and/or other drugs? ❑ Yes ❑ No
41. Have you ever been treated for substance abuse? ❑ Yes ❑ No
42. Do you currently have or in the past had an eating disorder? ❑ Yes ❑ No

43. Do you have anxiety about your dental visits? ❑ Yes ❑ No

229 Charles Street Westfield, NJ 07090

Phone: 908.389.0222 Fax: 908.389.0223

www.DoctorMerriman.com email: Info@doctormerriman.com

44. What is the reason for your visit today? ____

____

45. What was done at your last dental visit? ____

46. Do you have any dental problems now? ❑ Yes ❑ No

If yes, please describe: ____

47. Do you brush, floss, or use any dental aides? ❑Yes ❑ No

Please list: ____

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.

Signature: ____Date: ________________

Patient, parent or guardian