Dr. Joseph Muscatiello D.M.D

96 Plainfield Ave.

Edison, NJ 08817

(732) 985-1120 FAX (732) 985-2445

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected heath information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.
I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

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Patient: _____

Address: _____

D.O.B: _____

I acknowledge that I am financially responsible for all services in connection with the dental care and treatment rendered by Dr Muscatiello's office. This for applies to all services provided by our office.

I understand I am responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service. In the event payments are not received, I understand that a 2% interest charge may be added to my account.

I understand my insurance carrier may not approve or reimburse dental services due, but not, limited to:

- Usual and customary rates
- Benefit exclusions
- Non- covered or cosmetic services
- Lack of authorization
- Dental necessity
- Out Of Network provider (we accept Delta Dental Premier Only)

I understand that I am responsible for Non- reimbursement fees, Co-Payments, deductibles and co-insurance, except where any liability may be limited by State of Federal Law.

Signature Patient or Guardian: _____ Date: _____

Printed name patient or Guardian: _____

Medical and Dental History

Date _____

Name _____ Home Phone _____
Last First Middle

Bus. Phone _____

Address _____
Number Street City State & Zip Code

Occupation--Employer _____ Ins.Co. _____

Age___ Date of Birth __/__/__ Sex M F Height _____ Weight _____ Marital Status___

S.S. #_____ Credit card and # _____

Spouse's name and employer _____ Ins. Co. _____

If you are completing this form for another person, what is your relationship to that person? Are you financially responsible for this account. _____

Primary Dental Ins. Co. _____ Group # _____ Date employed _____

Union or local # _____ If there's a secondary carrier duplicate above info. below

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1. Have you been under a physician's care during the past two years?..... yes no
   Physician's Name _____ Phone _____
   Address _____
2. Have you taken any medication or drugs during the past two years?..... yes no
3. Are you taking medication, drugs or pills now?.....yes no
   List _____
4. Are you allergic to any medication or substance? If yes, list. _____
5. Indicate which of the following pertain to your health history:

Heart disease surgery.....yes no	Ulcers..... yes no	Hepatitis A, B, C, etc..... yes no
chest pain.....yes no	diabetes..... yes no	venereal disease..... yes no
heart murmur.....yes no	thyroid problems yes no	A.I.D.S..... yes no
high blood pressure..... yes no	contact lenses..... yes no	H I V positive..... yes no
mitral valve prolapse.....yes no	emphysema .....yes no	cold sores-fever blisters.....yes no
heart pacemaker .....yes no	chronic cough .....yes no	blood transfusion..... yes no
arthritis-rheumatism..... yes no	tuberculosis..... yes no	hemophilia.....yes no
swollen ankles..... yes no	asthma..... yes no	sickle cell disease.....yes no
stroke..... yes no	hay fever.....yes no	bruise easily ..... yes no
diet(special-restricted)..... yes no	sinus problems.....yes no	liver disease.....yes no
artificial joints .....yes no	cancer tumors.....yes no	neurological disorders.....yes no
kidney problems ..... yes no	anemia.....yes no	epilepsy or seizures.....yes no
abnormal bleeding .....yes no	anxious, nervous... yes no	dizzy spells.....yes no
psychiatric care .....yes no	pregnant.....yes no	taking birth control pills.....yes no

6. Do you have any health problems not listed? If so please describe: _____

_____

_____

_____

_____

Dental History

What is the reason for your visit today? _____

Referred by _____

Date of last Dental visit, and what was done. _____

Previous Dentist, address, and reason for leaving. _____

What pain control methods were used (ie; novacaine, nitrous oxide, put to sleep), and was any adverse reaction observed? _____

How often do you brush? _____ , floss? ____, Other dental aids? _____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
Have tired jaws, especially in the morning?	Yes	No

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No

Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No

Do you:		
Snore, or have difficulty breathing or sleeping at night?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Hold foreign objects with your teeth ? (pencils,pipe, pins, nails, fingernails)	Yes	No
Smoke/chew tobacco?	Yes	No
Feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? _____

Does food tend to become caught in between your teeth?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

If yes, where _____

Are you satisfied with your teeth's appearance? If no what's your biggest concern? _____

Is there anything else about having your dental treatment you'd like us to know? If yes, describe. _____

I have answered all questions to the best of my knowledge and I will notify the doctor of any change in my health. I authorize this office to utilize any diagnostic aids needed to make a thorough diagnosis. I will not hold this office responsible for any errors or omissions I have made. _____

signature of patient, or guardian

History review - - - - Date _____