JONATHAN DENTAL SPA
THE CENTER FOR COSMETIC & IMPLANT DENTISTRY
262 Lafayette Avenue • Hawthorne, NJ 07506 • (973) 423-4460

WELCOME!!!!

We would like to welcome you once again to our dental practice and explain a little about our office policies and goals. We believe in the theories of modern dental care which do not support the old premise of "When it hurts - fix it." Through proper preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep all of their teeth for many years to come.

Our patients can expect from us:
1. A high degree of professional skill and ability.
2. A dedication to your oral healthcare.
3. A minimization of costly reconstructive work through proper preventive care.
4. The highest effort to make your visits as comfortable as possible.
5. The right treatment at the right time.
6. Fees that are fair and just for the services provided.

In return, we expect from our patients:
1. Cooperation in making and keeping appointments.
2. A conscientious effort toward good oral hygiene.
3. Recall visits to maintain optimum oral health.
4. Arrangement for the payment of fees at the time of service.

In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that at any time you have a question or are unhappy about any treatment, fee for service, or attitude of our dental team, you will discuss it with us promptly and openly. Misunderstandings and/or lack of communication are the only obstacles to our continued friendship and professional relationship. If we have recommended treatment to correct any current conditions, please call our office to make an appointment for a return visit at your earliest possible convenience. Please feel free to visit our website at www.jonathandentalspa.com or www.thehawthornedentist.com to find out more about our practice. We have enclosed the forms needed to be filled out prior to your appointment. Please don't forget to bring them in, so that we can see you in a timely manner.

Sincerely,
The Oral Health Team @ Jonathan Dental Spa

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print) Date: ____________________

Name ____

Address ____

____

Phone Numbers

Home ____________________ Work ________________ Cell ____________________

Where do you prefer to receive calls at? (We will make this your main number) ____________________

Birth Date ________________________ Social Security ____________________________

Are you:
Married Widowed Single Minor Separated Divorced Partnered for ____ years

Patient Employer/School ______________________ City __________________

Occupation ____

Whom may we thank for referring you to us? ______________________________

Person to contact in Case of emergency ________________ Phone ____________

Insurance Information

Name of Insured ______________________ Relationship to Pt. ______________

Birth Date ____________________ Social Security ______________________

Name of Employer ______________________ Date Employed ______________

Insurance Company ____________________ ID# ______________________

Group # ______________________________

Have you seen another dentist this year that might have utilized your insurance this year? ____________
Do you have additional Insurance? ______________________ If yes, please input on back of this form.

I certify that I, and/or my dependents, have insurance coverage with the above named company and I assign directly to Jonathan Dental Spa all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Dr Abenaim may use my healthcare information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____________________
Signature of Patient, Parent or Guardian Date

Medical History- Confidential

Physician Name: ____________________
Phone #: ____________________

Are you in Good Health?

____

Do you Smoke?

____

Have you ever had a serious illness, operation, or hospitalization?

____

Are you now under the care of a physician for any ongoing treatment or therapy?

____

My last Physical examination was on:

____

Are you now taking any medicine, drugs or pills? (Diet pills count!)
__________ **Please list** ____________________

Do you have any allergies?
__________ **If yes to what?** ____________________

Do you or any member of your family have diabetes?

____

Do you have a blood disorder or do you bleed excessively?

____

Have you ever had injury, surgery, or X-ray therapy to face or jaws?

____

Do you have a tendency to faint?

____

Do you have frequent sever headaches?

____

Are you on a special diet?

____

Do you have a prosthetic implant/ (i.e. hip knees?)

____

WOMEN ONLY – Are you pregnant? __________ **Which Month?** __________
Are you nursing? __________
Are you taking birth control pills?

Do you have any disease, condition or problem not listed above that you think the dentist should know about? ____________________

____

Please see reverse side

Circle if you have had any of the following:

AIDS
Anemia
Arthritis,
Rheumatism
Artificial Heart Valve
Artificial Joints
Asthma
Back Problems
Bleeding Abnormally
Blood disease
Cancer
Chemical Dependency
Chemotherapy
Circulatory Problems
Congenital Heart Lesi
Cortisone Treatments
Cough, Persistent

Cough up blood
Diabetes
Drug Addiction
Epilepsy
Fainting
Glaucoma
Headaches
Heart Murmurs
Heart Problems
Hemophilia
Hepatitis
Hernia
High Blood Pressure
HIV positive
Jaw Pain
Kidney Disease

Liver Disease
Lung Disease
Mitral Valve Prolapse
Mental Problems
Nervous Problems
Pace Maker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Skin Rash
Stroke
Swelling of feet or ankles
Thyroid Problems

Tobacco Habit
Tonsillitis
Tuberculosis
Ulcer
Venereal Infection

Certification:

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.

_______________________________ **Signature of Patient, Parent or Guardian**

_______________ **Date**

_______________________________ **Please print name of Patient, Parent or Guardian**

_______________ **Relationship**

Dental History

What concerns you most about your dental health? ______________________
Do you see a dentist on a routine basis? ______________________
Date of last: Dental visit__________ Dental Cleaning__________ Full Mouth Xrays__________
Are you having pain at this time? ______________________

Have you ever had?

Orthodontic Treatment (braces) ______________________
Oral Surgery______________________
Periodontal Treatment (gum surgery) ______________________
Worn a Night Guard or other appliance? ______________________
Have you noticed any loosening of your teeth? ______________________
Does food tend to become caught between your teeth? ______________________

Problems of the jaw..... Have you experienced:

Clicking of the jaw? ______________________
Pain (joint, ear, side of face) ______________________
Difficulty in opening or closing? ______________________
Difficulty chewing? ______________________

Habits......Do you:

Clench or grind your teeth while awake or asleep? ______________________
Bite your lips or cheeks regularly? ______________________
Hold foreign objects with your teeth? Such as pencils, pipes, pins, nails, fingernails? ______________________
Mouth Breath while asleep? ______________________

Conditions.....

Sensitivity to cold______________________
Sensitivity to hot______________________
Sensitivity to sweets______________________
Sensitivity when biting______________________
Bad Breath______________________
Sores or growths in your mouth______________________

Do you feel nervous about having dental treatment? ______________________
Have you ever had an upsetting experience at the dentist? ______________________
Is it important to keep your teeth? ______________________
If you could what features of your smile would you like to change? ______________________
Is there anything else about having dental treatment that bothers you? ______________________

____

Insurance companies now only allow for "functionally acceptable work", whereas, in the past their coverage was for "quality work". It is our desire to provide our patients with the highest quality of work within their financial capabilities and desire.

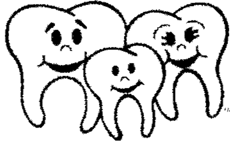
What is important to you? (Please circle)

The highest quality of dentistry available
The most economical treatment plan
Dentistry limited to insurance coverage
A combination of the above, please explain:______________________

Consent:

The undersigned hereby authorizes the dentist to take x-rays. Study models, photographs, or any diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my treatment, after discussion and consultation between me and the dentist including alternative options or the consequences of no treatment. I also authorize the use of any models or photographs to be used for marketing and educational purposes. I also understand the use of anesthetic agents embodies a certain risk.

______________________Signature and Date



Jonathan Dental Spa
262 Lafayette Ave
Hawthorne, NJ 07506

At **Jonathan Dental Spa**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.........

Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

We bill your insurance as a courtesy. If insurance does not pay within 90 days, **Jonathan Dental Spa** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Cerec Onlays and Crowns: Most insurance companies have an allowance for **BASIC** materials used in restorative procedures and my provider can not balance bill for the basic materials. I understand that a Cerec Restoration is kinder to natural teeth than traditional porcelain. After discussing my treatment and the available options, If I decide to upgrade the material types being used I agree to pay the difference in cost to the amount my insurance company allows.

Jonathan Dental Spa does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). We **do not accept** checks for over $500.00 for any patient. If you are in need of an extended finance option, we also work with Care Credit, who offers a twelve month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the patient services staff for an application.

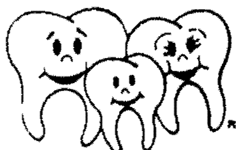
Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$50/hour cancellation fee** (emergencies are an exception). Any family who is scheduled for an excess of 2 hours will be charged **$50 per appointment.**

After Hours/Weekend Emergencies: In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee.**

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Sign: ______________________________

Print: ______________________________



Jonathan Dental Spa
262 Lafayette Ave
Hawthorne, NJ 07506

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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

Restrictions: 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.

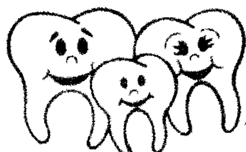
QUESTIONS AND COMPLAINTS

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:	Hidee Robbins
Telephone:	973-423-4460
Fax:	973-423-3126
Address:	262 Lafayette Ave Hawthorne, NJ 07506



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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

____

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