DRS. FREED and GLIKSMAN

George Freed DMD Jeffrey Gliksman DMD
155 North Washington Ave, Bergenfield, NJ 07621 - (201) 384-3909

# Patient Information Form

**Today's Date** _____

**Patient Name:** First _____ MI ___ Last _____ Nickname _____

**Address:** Street _____ City _____ State _____ Zip _____

**Phone:** Home _____ Work _____ Mobile _____

**E-mail address** _____

**By Providing your e-mail address you agree to receive** *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

**What is your preferred method of contact?** ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

**Social Security Number** _____ **Date of Birth** _____

**Drivers License #** _____ **State** _____

**Patient Employed By** _____ **Occupation** _____ **Phone** _____

**Address:** Street _____ City _____ State _____ Zip _____

**Sex** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

**In case of emergency, who should be notified?** _____

**Relationship to Patient** _____ **Home Phone** _____ **Mobile Phone** _____

---

**Is the patient a Minor?** ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

**Name of Responsible Party:** First _____ Last _____

**Date of Birth** _____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

**If patient is a Minor, primary residency** ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

**Address:** *(if different from patient)* Street _____ City _____ State _____ Zip _____

**Phone:** Home _____ Work _____ Mobile _____

**Employer** *(if different from above)* _____ **Occupation** _____ **Phone** _____

**Address:** Street _____ City _____ State _____ Zip _____

---

## Dental Benefit Plan Information

**Primary Dental Plan Name** _____ **Phone** _____

**Address:** Street _____ City _____ State _____ Zip _____

**Name of Insured** _____ **Date of Birth** _____ **ID Number** _____

**Policy Number** _____ **Patient Relationship to Insured** _____

**Secondary Dental Plan Name** _____ **Phone** _____

**Address:** Street _____ City _____ State _____ Zip _____

**Name of Insured** _____ **Date of Birth** _____ **ID Number** _____

**Policy Number** _____ **Patient Relationship to Insured** _____

**Whom may we thank for referring you?** _____

DRS. FREED and GLIKSMAN

George Freed DMD Jeffrey Gliksman DMD
155 North Washington Ave. Bergenfield, NJ 07621 - (201) 384-3909

Patient's Name: _____

# MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS | ☐ | ☐ | Dizziness | ☐ | ☐ | HIV Positive | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Allergies (Seasonal) | ☐ | ☐ | Drug Addiction | ☐ | ☐ | HPV (Human Papilloma Virus) | ☐ | ☐ | Seizures | ☐ | ☐ |
| Anemia | ☐ | ☐ | Emphysema | ☐ | ☐ | Jaundice | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Angina (Chest pain) | ☐ | ☐ | Epilepsy | ☐ | ☐ | Jaw Joint Pain | ☐ | ☐ | Sleep Apnea | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stomach Problems | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Fainting | ☐ | ☐ | Liver Disease | ☐ | ☐ | Stroke | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Glaucoma | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Conditions | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | Heart Lesions (Congenital) | ☐ | ☐ | Nervousness/Depression | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Bruise Easily | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Pacemaker | ☐ | ☐ | Venereal Diseases | ☐ | ☐ |
| Cancer | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Pregnant Currently | ☐ | ☐ | Other _____ | | |
| Cervical Cancer | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Radiation (head/neck) | ☐ | ☐ | | | |
| Chemotherapy | ☐ | ☐ | Hepatitis B | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | | | |
| Cortisone Medication | ☐ | ☐ | Hepatitis C | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | | | |
| Diabetes | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Rheumatism | ☐ | ☐ | | | |

Are you allergic or have you reacted adversely to any of the following medications?

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aspirin | ☐ | ☐ | Percodan | ☐ | ☐ | Tetracycline | ☐ | ☐ | Valium | ☐ | ☐ |
| Darvon | ☐ | ☐ | Latex | ☐ | ☐ | Codeine | ☐ | ☐ | Penicillin | ☐ | ☐ |
| Nitrous Oxide | ☐ | ☐ | Local Anesthetic | ☐ | ☐ | Erythromycin | ☐ | ☐ | Sulfa | ☐ | ☐ |

Other _____

Have you ever taken any the following medications?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Actonel | ☐ | ☐ | Zometa | ☐ | ☐ |
| Aredia | ☐ | ☐ | Boniva | ☐ | ☐ |
| Fosamax | ☐ | ☐ | Herbal Supplements | ☐ | ☐ |
| Reclast | ☐ | ☐ | | | |

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

_____

_____

Family Physician Phone Number

_____

***Consent:***

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents emoodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

**Patient Signature** (Parent if child) **Date** **Dentist Signature**

DRS. FREED and GLIKSMAN

George Freed DMD Jeffrey Gliksman DMD
155 North Washington Ave. Bergenfield, NJ 07621 - (201) 384-3909

Patient's Name: _____

# DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last full mouth X-rays _____

Name of Previous Dentist _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations _____

How often do you brush your teeth _____ How often do you floss _____

Have you used or currently using Topical Fluoride [ ] Yes [ ] No

What other dental aids do you use? _____

Do you have any dental problems now? [ ] Yes [ ] No

If yes, please describe _____ _____

| **Are your teeth sensitive to:** | Yes | No |
|---|---|---|
| Hot or cold? | ☐ | ☐ |
| Sweets? | ☐ | ☐ |
| Biting or Chewing? | ☐ | ☐ |
| Have you noticed any mouth odors or bad tastes? | ☐ | ☐ |
| Do you frequently get cold sores, blisters, or any other oral lesions? | ☐ | ☐ |
| Do your gums bleed or hurt? | ☐ | ☐ |
| Have either parent experienced gum disease or tooth loss? | ☐ | ☐ |
| Have you noticed any loose teeth or change in your bite? | ☐ | ☐ |
| Does food tend to become stuck in between your teeth? | ☐ | ☐ |

| **Do You:** | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | ☐ | ☐ |
| Bite your lips or cheeks regularly? | ☐ | ☐ |
| Hold foreign objects in your teeth? (pencils, pipe, pins, nails, fingernails) | ☐ | ☐ |
| Mouth breathe while awake or asleep? | ☐ | ☐ |
| Have tired jaws, especially in the morning? | ☐ | ☐ |
| Snore or have any other sleeping disorders? | ☐ | ☐ |
| Smoke/chew tobacco or other tobacco products? | ☐ | ☐ |

| **Have you ever had:** | Yes | No |
|---|---|---|
| Orthodontic Treatment? | ☐ | ☐ |
| Oral Surgery? | ☐ | ☐ |
| Periodontal Treatment? | ☐ | ☐ |
| Your teeth ground or the bite adjusted? | ☐ | ☐ |
| A bite plate or mouth guard? | ☐ | ☐ |
| A serious injury to the mouth or head? If so, please describe, including cause _____ | ☐ | ☐ |

| **Have you experienced:** | | |
|---|---|---|
| Clicking or popping of the jaw? | ☐ | ☐ |
| Pain in your joint, ear, side of face? | ☐ | ☐ |
| Diffculty chewing on either side of mouth? | ☐ | ☐ |
| Headaches, Neckache or shoulder aches? | ☐ | ☐ |

| If I could change my smile, I would: | | |
|---|---|---|
| -Make it whiter | ☐ | ☐ |
| -Make it straighter | ☐ | ☐ |
| -Close spaces | ☐ | ☐ |
| -Replace black metal fillings with tooth colored restorations | ☐ | ☐ |
| -Repair chipped teeth | ☐ | ☐ |
| -Replace missing teeth | ☐ | ☐ |
| -Replace old crowns that don't match | ☐ | ☐ |
| -Have a smile makeover | ☐ | ☐ |

Have you ever been told to take pre-medication prior to dental treatment? [ ] Yes [ ] No

Is there anything else about having Dental Treatment that you would like us to know? [ ] Yes [ ] No

If yes, please describe _____ _____

DRS. FREED and GLIKSMAN

# Consent for Treatment of Minors In Parent/Legal Guardian Absence

Patient Name:_____ Date of Birth:_____ Age: _____

To allow for treatment of patients who are considered minors it is necessary for a parent (not step-parent/foster parent) or legal guardian to give consent for treatment. In the event that a parent or legal guardian is unable to consent to the care the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I/We understand that a local anesthetic injection may be given and that in rare situations, patients can have an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I/We understand that the injection area(s) may be uncomfortable following treatment, and that the jaw can be stiff and sore from the mouth being held open during treatment.

I/We _____(parent's name) authorize the Dentist(s) and the Dental Team at Drs. Freed and Gliksman to provide treatment at 155 North Washington Ave, Bergenfield NJ, 07621.

Appointee's name_____ Relationship_____

Appointee's address _____

Appointee's phone number_____

To consent to:
_____Emergency or urgent care when I cannot be reached.
_____Any and all necessary dental care and treatment as determined by the Dentist.

For my child: Child's name _____

During the period:

_____Date (month/day/year) ____/____/_____ to _____/____/____

_____For a maximum period of 1 year

I can be reached at the following numbers if there are questions:

Home: (____)_____-_____
Work: (____)_____-_____
Cell: (____)_____-_____

I further agree to reimburse the Dental Office for the cost of rendering these services to the extent that my insurance does not pay for these services.

(Signature of Parent/ Legal Guardian)_____

(Print Name)_____ (Relationship)_____

(Child's parent/legal guardian address) _____

(Date)_____

# DRS. FREED and GLIKSMAN

**George Freed DMD  Jeffrey Gliksman DMD**

**155 North Washington Avenue, Bergenfield, NJ 07621 - (201) 384-3909**

## FINANCIAL / OFFICE POLICIES

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available upon request and approval.
**Please check if you would like more information about financing options.** ☐

***Please Note:*** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

### Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express, or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

**We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.**

### Authorization and Consent

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENE- FITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.
By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

**Patient Signature** (Parent if child) **Date**

_____

**Print Name**


George Freed, D.M.D.

Jeffrey Gliksman, D.M.D.

155 North Washington Avenue Bergenfield, NJ 07621

# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I, _____, have received a copy of the Notice of

Privacy Practices from _____.

_____

Patient Name (Print)

_____ _____

Signature Relationship to Patient

_____

Date

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

¡ Patient/Individual refused to sign (Date of refusal)_____

¡ Communications barriers prohibited obtaining an acknowledgement