

MAHESH U. PATEL, D.D.S.

CROSS KEYS MEDICAL AND DENTAL CENTER
600 BERLIN-CROSSKEYS RD. SUITE 100
SICKLERVILLE, NJ 08081
(856) 875-5598

NAME LAST	FIRST	MI	BIRTH DATE MO DAY YR	SOCIAL SECURITY NO. - -	SEX M <input type="radio"/> F <input type="radio"/>
STREET			DEVELOPMENT		
CITY			STATE		
ZIP			PHONE NO. (HOME)		
			PHONE NO. (WORK)		

MEDICAL - HISTORY

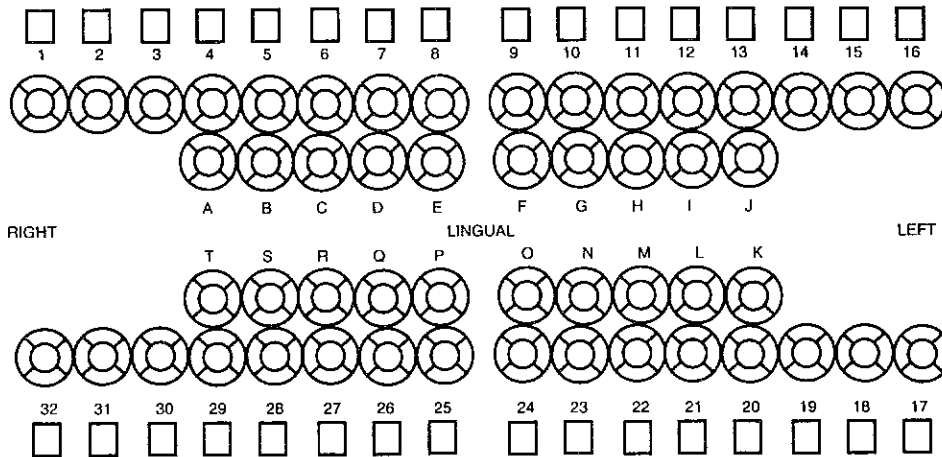
EACH QUESTION MUST BE ANSWERED

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|------------|--------------------|-----------|---------------------------|---------|---------------|---------------|---------------|-----------------------|-------|----------------------|------------|------------------------|---------|-----------|----------------|------------------|-----------|-----------------------|---|---|---|---|---|---|---|---|---|---|
| | CHECK ONE
YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST YEAR ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. ARE YOU TAKING ANY MEDICATIONS ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. HAS ANYONE IN YOUR FAMILY BEEN ADVISED OF DIFFICULTIES DURING ANESTHESIA ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. ARE YOU ALLERGIC TO PENICILLIN, CODEINE, VALIUM, OR ANY OTHER DRUGS OR MEDICINES ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. HAVE YOU EVER HAD ANY OF THE FOLLOWING ? (CIRCLE) | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">HEART TROUBLE.</td> <td style="width: 33%;">ASTHMA.</td> <td style="width: 33%;">ARTHRITIS.</td> </tr> <tr> <td>VENEREAL DISEASES.</td> <td>DIABETES.</td> <td>CONGENITAL HEART LESIONS.</td> </tr> <tr> <td>STROKE.</td> <td>HIV POSITIVE.</td> <td>HEART MURMUR.</td> </tr> <tr> <td>TUBERCULOSIS.</td> <td>EPILEPSY OR SEIZURES.</td> <td>AIDS.</td> </tr> <tr> <td>HIGH BLOOD PRESSURE.</td> <td>HEPATITIS.</td> <td>PSYCHIATRIC TREATMENT.</td> </tr> <tr> <td>ANEMIA.</td> <td>JAUNDICE.</td> <td>SINUS TROUBLE.</td> </tr> <tr> <td>RHEUMATIC FEVER.</td> <td>GLAUCOMA.</td> <td>DIFFICULTY BREATHING.</td> </tr> </table> | HEART TROUBLE. | ASTHMA. | ARTHRITIS. | VENEREAL DISEASES. | DIABETES. | CONGENITAL HEART LESIONS. | STROKE. | HIV POSITIVE. | HEART MURMUR. | TUBERCULOSIS. | EPILEPSY OR SEIZURES. | AIDS. | HIGH BLOOD PRESSURE. | HEPATITIS. | PSYCHIATRIC TREATMENT. | ANEMIA. | JAUNDICE. | SINUS TROUBLE. | RHEUMATIC FEVER. | GLAUCOMA. | DIFFICULTY BREATHING. | <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="radio"/> <input type="radio"/></td> <td style="width: 33%;"><input type="radio"/> <input type="radio"/></td> <td style="width: 33%;"><input type="radio"/> <input type="radio"/></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/></td> </tr> </table> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| HEART TROUBLE. | ASTHMA. | ARTHRITIS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| VENEREAL DISEASES. | DIABETES. | CONGENITAL HEART LESIONS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| STROKE. | HIV POSITIVE. | HEART MURMUR. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TUBERCULOSIS. | EPILEPSY OR SEIZURES. | AIDS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HIGH BLOOD PRESSURE. | HEPATITIS. | PSYCHIATRIC TREATMENT. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ANEMIA. | JAUNDICE. | SINUS TROUBLE. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RHEUMATIC FEVER. | GLAUCOMA. | DIFFICULTY BREATHING. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. (WOMEN) ARE YOU PREGNANT NOW ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. (WOMEN) ARE YOU TAKING ANY BIRTH CONTROL PILLS ? | <input type="radio"/> <input type="radio"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. PERMISSION: I HEREBY AGREE AND GIVE MY UNQUALIFIED CONSENT TO ANY EXAMINATIONS, ANESTHETIC, TREATMENT THAT THE ATTENDING PHYSICIAN, DENTIST OR ASSISTANTS MAY DEEM NECESSARY OR ADVISABLE. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FINANCIAL ARRANGEMENT PVT. <input type="radio"/> INS. <input type="radio"/>	
RELATIONSHIP TO SUBSCRIBER SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT <input type="radio"/>	
AGREEMENT NO. _____	
PRIMARY INS.	SECONDARY INS.
NAME OF INSURANCE CO.	NAME OF INSURANCE CO.
NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
POLICY HOLDERS S.S.#	POLICY HOLDERS S.S.#
DATE OF BIRTH	DATE OF BIRTH
EMPLOYER'S NAME, ADDRESS & PHONE NUMBER	EMPLOYER'S NAME, ADDRESS & PHONE NUMBER

12. REFERRED BY _____

SIGNED _____
PATIENT OR NEAREST RELATIVE IN THE CASE WHEN THE PATIENT IS A MINOR OR PHYSICALLY OR MENTALLY INCOMPETENT.



PERDONTAL EXAMINATION INFLAMMATION OF

- | | | |
|-----------------|---|--------------|
| GINGIVAL TISSUE | <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE | OTHER: _____ |
| CALCULUS | <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE | _____ |
| RECESSION | <input type="checkbox"/> SLIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE | _____ |

1.		16.		17.		32.		PROTHESIS: INITIAL PLACEMENT <input type="radio"/> REPLACEMENT <input type="radio"/> EXTRACTION DATES OF MISSING TEETH _____ REASON FOR REPLACEMENT _____
2.		15.		18.		31.		
3.		14.		19.		30.		
4.		13.		20.		29.		
5.		12.		21.		28.		
6.		11.		22.		27.		
7.		10.		23.		26.		
8.		9.		24.		25.		



APPLE DENTAL CENTER

Cross Keys Medical & Dental Center – 600 Berlin-Cross Keys Rd – Suite 100 – Sicklerville, NJ 08081
PHONE: (856) 875 – 5598 – FAX: (856) 875 – 4501

Getting to know you:

Name: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

What dental concern do you have today: _____

Would you like a free smile/cosmetic analysis? _____

Would you like a free analysis to remove wrinkles and enhance lips with
dermal fillers? _____

Occupation: _____

Referred By: ___ Yellow Pages Gloucester County
 ___ Yellow Pages Camden County
 ___ Yellow Book
 ___ Building
 ___ Insurance Listing – Name of Insurance _____
 ___ Friend/Family Member – Name _____
 ___ Other-If so explain: _____

Name of Physician/Specialist: _____

Telephone Number: _____

Previous Dentist/Dental Office: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, 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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



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SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE _____ EMAIL _____ SS# _____

SECTION B: TO PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

Contact Person: Mary Anne Rempfer
Telephone: 856 875 5598 Fax: 856-875-4501

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form. I am giving my consent to your use and disclosure of my protect health information to carry out treatment payment activities and health care operations.

Signature: _____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

For Children Only

Personal Representative's Name: _____

Relationship to Patient: _____