Health History Form

ADA. American Dental Association www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: include area code ( ) Business/Cell Phone: include area code ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort? ☐ ☐ ☐

What is the reason for your dental visit today?

How do you feel about your smile?

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: include area code ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Form 5500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: ____ If yes, have you had any complications? ____	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began: ____	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____	☐	☐	☐
Aspirin ____	☐	☐	☐
Penicillin or other antibiotics ____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____	☐	☐	☐
Sulfa drugs ____	☐	☐	☐
Codeine or other narcotics ____	☐	☐	☐

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ____ If yes, how much do you typically drink in a week? ____	☐	☐	☐

WOMEN ONLY Are you:

Pregnant? Number of weeks: ____	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

	Yes	No	DK
Metals ____	☐	☐	☐
Latex (rubber) ____	☐	☐	☐
Iodine ____	☐	☐	☐
Hay fever/seasonal ____	☐	☐	☐
Animals ____	☐	☐	☐
Food ____	☐	☐	☐
Other ____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: ____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: ____	☐	☐	☐
Sleep disorder	☐	☐	☐
Mental health disorders Specify: ____	☐	☐	☐
Recurrent infections Type of infection: ____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments:

NEW PATIENT

1 ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: _____

Payment method: ☐ Cash ☐ Check

_____ / _____

☐ Credit Card - Enter card # above (If accepted)

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).

4 IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PLEASE COMPLETE BACK

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take X-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs. I also acknowledge that costs associated with certain procedures may not be covered by my insurance provider.

_____

2. Upon such diagnosis, I authorize doctor or designated staff to perform all recommended treatment agreed upon by me and as required to provide proper care. I acknowledge that all costs associated with these procedures may not be covered by my insurance provider.

_____

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____

4. I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made. In the event payments are not received within 30 days, I understand that a 1.5% late charge (18% APR) plus a monthly billing charge of $2.50 will be added to my account.

_____

5. A collection fee representing one third of the outstanding balance will be added if the account is referred for collections to an outside company or attorney. _____

Patient_____ Date_____

Witness_____

Parent or Guardian_____ Date_____

Relation to Patient_____

(3)

THE SMILE SPA OF NORTH JERSEY, LLC

PATIENT'S
NAME_____

PARENT OR GUARDIAN'S
NAME_____

INSURANCE
NAME_____GROUP#_____

ID#_____DATE_____

MISSED APPOINTMENT POLICY:

I HAVE BEEN THOROUGHLY INFORMED THAT ACCORDING TO THE AGREEMENT WITH MY INSURANCE COMPANY ALL APPOINTMENTS MUST BE KEPT UNLESS TWENTYFOUR HOUR'S NOTICE IS GIVEN.

IF FOR ANY REASON I DO NOT KEEP MY APPOINTMENT, OR CANCEL AND DO NOT GIVE TWENTYFOUR HOUR'S NOTICE, THERE WILL BE A DISAPPOINTMENT CHARGE OF $25.00 FOR GENERAL DENTIST PER EACH ¼ HOUR AND $50.00 PER EACH ¼ HOUR FOR PERIODONTIST, UNLESS MANDATED DIFFERENTLY BY YOUR INSURANCE COMPANY. ****NO INSURANCE COMPANY COVER BROKEN APPOINTMENT FEES UNDER ANY CIRCUMSTANCES!

**** ALL MONDAY APPOINTMENTS THAT NEED TO BE CHANGED, MUST BE CHANGED ON THE FRIDAY PRIOR TO YOUR VISIT.

DUPLICATION OF X-RAYS POLICY:

THERE WILL BE A $30.00 DUPLICATION FEE ON EACH SET OF X-RAYS REQUESTED. IN ADDITION, THE OFFICE WILL NEED A WRITTEN AUTHORIZATION RELEASE FROM THE PATIENT.

COPAYMENT POLICY:

ALL CO-PAYMENTS ARE DUE AT TIME OF SERVICE. IF CO-PAYMENT IS NOT PAID AT TIME OF SERVICE THERE WILL BE A $10.00 SURCHARGE ADDED. PLEASE SEND COPAYMENTS WITH ANY CARETAKER WHO BRINGS YOUR CHILD TO THE OFFICE.

_____

PATIENT OR PARENT/GUARDIAN SIGNATURE

The Smile Spa of North Jersey, LLC

759 Lafayette Avenue, Hawthorne, NJ 251 Godwin Avenue, Midland Park, NJ

PATIENT ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND AUTHORIZATION/RELEASE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____ Authorization to expire on ___/___/___ If no date is stated, the expiration date will be 12 months from the date of this authorization.

The undersigned acknowledges receipt of the currently effective Notice of Privacy Practices for The Smile Spa of North Jersey, LLC. A copy of this signed, dated document shall be as effective as the original. I have read and understood the terms of this authorization. I have also had a chance to ask questions about how my health information will be used and disclosed. By signing this authorization, I am affirming that to the best of my knowledge all information provided on this form is complete, accurate and consistent with my directions. I hereby provide my agreement to the terms authorizing the use and disclosure of my health information in the manner described in this form. I have to right to cancel this authorization at any time, and that the cancellation must be in writing and sent to the address noted on this form.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
[ ] First name only [ ] Surname (Mrs. Smith) [ ] Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouse, stepparent, grandparent and any caretakers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THE SMILE SPA OF NORTH JERSEY, LLC *TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION* VIA:

[ ] Cell phone confirmation [ ] Text message to my cell phone [ ] Home phone confirmation
[ ] Work phone confirmation [ ] E-mail confirmation [ ] Any of the above

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____ _____
Patient please *print* your name Patient please *sign* your name

_____ _____
Legal Representative Signature (Parent or Guardian) Description of Authority (Relation to Patient)

Office Use Only
As privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

[ ] It was emergency treatment [ ] I could not communicate with the patient
[ ] The patient refused to sign [ ] The patient was unable to sign because_____
[ ] Other: _____ Signature of Privacy Officer:_____

The Smile Spa
OF NORTH JERSEY, LLC

DR. DEBRA R. ROSENBLATT, I

FINANCIAL POLICY

Our office is committed to providing the best possible dental care for you. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, our financial policy, or your financial responsibility.

PARTICIPATING INSURANCE PLANS

We require you to show your current insurance card at each office visit. If your insurance company does not respond to our claim's submission, we will submit the claim a second time. If they have failed to pay after the second submission the balance will become your responsibility, and is due within 30 days of the billing. You are responsible for any deductible s and balance your insurance indicates on their explanation of benefits (EOB). These balances are due in full within 30 days of your first bill.

DIVORCE SITUATIONS

The parent who brings a child in for the visit is responsible for payment at the time of service regardless of the financial arrangements of the divorce. Our goal is to be able to provide the appropriate dental care for your child.

PATIENT ACCOUNTS

You are responsible for timely payment of your account. Any patient balance left after 120 days without any attempts at resolution will be considered delinquent and may be submitted to a collection agency. If you are having financial hardship, please speak with the billing office and we will make every effort to set up an acceptable payment plan with you. If an account is turned over to collection, we will be unable to provide any further dental care. Submission to a collection agency could affect your credit rating.

We accept cash, personal checks, Visa/ MasterCard, Discover, and American Express

X _____
initial

251 Godwin Ave
Midland Park, NJ 07432
Phone: 201-445-2797
Fax: 201-445-8340

759 Lafayette Ave
Hawthorne, NJ 07432

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

- **25% of oral cancers occur in people who don't smoke and have no other risk factors.**

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $ 90.00

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

38. Name, Address, City, State, Zip Code

39. NPI | 40. License Number | 41. SSN or TIN

42. Phone Number ( ) - | 42A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

43. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

44. Number of Enclosures (00 to 99) Radiographs# ____ Oral Impartial ____ Model(s) ____

45. Is Treatment for Orthodontics? ☐ No (Skip 45-46) ☐ Yes (Complete 45-46)

46. Date Appliance Placed (MM/DD/CCYY)

47. Months of Treatment Remaining

48. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 48)

49. Date Prior Placement (MM/DD/CCYY)

50. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

51. Date of Accident (MM/DD/CCYY)

52. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

19-4925 7/07