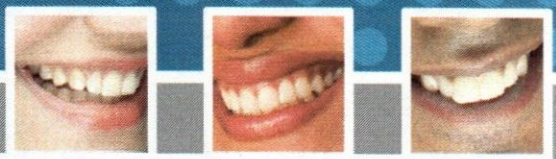
New Paradigm Dentistry
James C. Burden, DMD, FAGD
514 State Route 33W - Suite 3
Millstone Township NJ
(732)414-1888
newparadigm@optonline.net
www.NewParadigmDentistry.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

☐ Internet ☐ Physician/Dentist ☐ Insurance Web Site

☐ Drive/Walk By ☐ Community Event ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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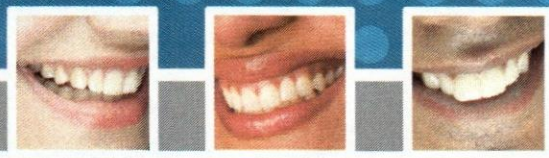

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

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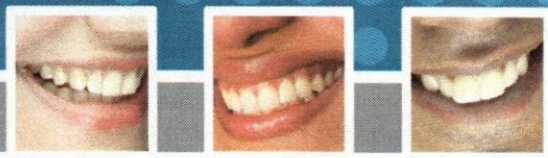

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ (City) _____ (State) _____ (Zip Code)

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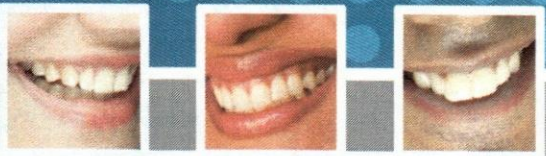

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

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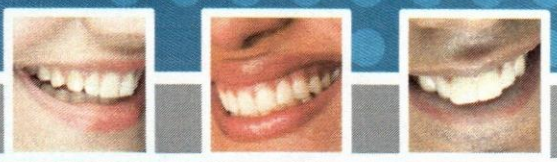

Medical Conditions

Please check all that apply.

☐ *PreMed Clindamycin	☐ *PreMed Other	☐ *PreMed-Amox	☐ Allergies
☐ Alzheimer's Disease	☐ Anemia	☐ Anxiety Disorder	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Avoid Epinepherine	☐ Avoid NSAIDs
☐ Blind	☐ Blood Disease	☐ Blood Thinners	☐ Cancer
☐ Cerebral Palsy	☐ CHF	☐ Cipro Allergy	☐ Codeine Allergy
☐ COPD/Emphysema	☐ Deaf	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Hay Fever	☐ Head Injuries	☐ Hearing Difficulties	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV-AIDS
☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease	☐ Memory Loss
☐ Mental Disorders	☐ Mitral Valve Prolaps	☐ Multiple Sclerosis	☐ Nervous Disorders
☐ NO EPI	☐ Pacemaker	☐ Parkinsons Disease	☐ Pemphagus Vulgaris
☐ Penicillin Allergy	☐ Polio	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Sinus Problems	☐ SRP	☐ Stomach Problems
☐ Stroke	☐ Sulfa Allergy	☐ Takes Aspirin	☐ Tobacco History
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

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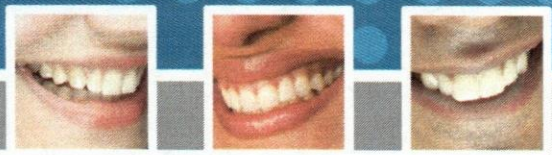

Please provide the name and phone number of your primary physician.

Please note any medications you take, reason, and dose.

Are you allergic to or have you ever experienced an unusual reaction to:

☐ Metals or Jewelry ☐ Dental Anesthesia ☐ Other

Are you taking or have you ever taken/been treated with Bisphosphonate (ie. Fosamax, Boniva, etc)?

◯ Yes ◯ No

Have you had a total joint replacement, an artificial heart valve, or endocarditis in the past?

◯ Yes ◯ No

Do you have any other medical conditions or concerns that were not addressed on this form?

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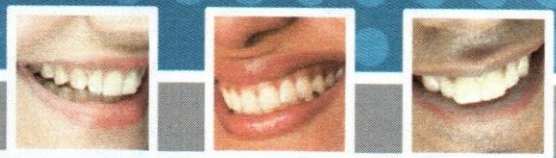

Dental Health Questions

On a scale of 1-10 (10 being the best), how would you rate your smile?

*

In your mind, what would get your smile to a perfect 10?

Have you noticed any of these? (Please check all that apply)

- ☐ Teeth that look worn or short
- ☐ Teeth that are sensitive to cold, hot, sweets, or biting pressure
- ☐ An unpleasant taste or persistent bad breath
- ☐ Food catches between your teeth and gums
- ☐ Gums that bleed at times when brushing
- ☐ Gums that have pulled away from teeth (Recession)
- ☐ Pus between gums and teeth
- ☐ Loose or separating teeth
- ☐ Broken teeth or fillings
- ☐ Changes in the way your teeth fit together
- ☐ Avoidance of any areas when brushing or chewing
- ☐ Clenching or grinding of teeth
- ☐ Clicking, snapping or difficulty when chewing
- ☐ Difficulty opening or moving the jaws
- ☐ Difficulty in speaking or changes in voice
- ☐ Lumps or swellings in the head and neck region
- ☐ Sores or rough spots in your mouth

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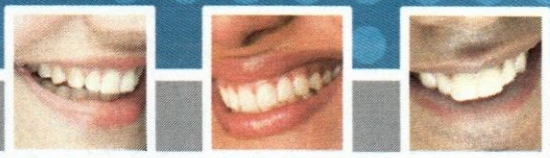

Financial Policy and Insurance Release

* ☐ Please check this box to indicate that you have read and understand the following:

We currently offer several payment options.
Option 1 Personal check, cash, Visa, MasterCard, Discover, American Express
Option 2 We offer a 5% courtesy to patients who pay in full for their treatment with cash or check prior to initiating a treatment plan of $1,500 or more.
Option 3 No Interest or Low Interest payment plans from Care Credit or Citi Healthcard
Option 4 Traditional Dental Insurance - If your employer has provided you with a dental insurance plan, we can directly bill them for the cost of your care. We can only estimate your out-of-pocket responsibility as employer sponsored dental plans differ in coverage amounts. Co-Pays and employer selected non-covered services can be handled with Options 1, 2, or 3 listed above. We are unable to submit claims for Medicaid and HMO plans.

New Paradigm Dentistry requires payment arrangements be made prior to the beginning of treatment. If you chose to discontinue treatment before case completion, your refund will be determined upon review of your case.

All fees charged by New Paradigm Dentistry are the sole responsibility of the patient or guardian regardless of insurance coverage or limitations.

A fee of $25 will be charged for returned checks.

A fee of $25 will be charged to patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Fraudulent Checks, Cash or Credit Cards will be reported to law enforcement.

Balances without financial arrangements that are unpaid after 60 days will be reported to the three major credit bureaus.

I have read, understand, and have had the opportunity to ask questions about payment options for services rendered by New Paradigm Dentistry. I understand the payment for services is my responsibility. I authorize payment of dental insurance benefits otherwise payable to me, to be paid directly to James C. Burden, D.M.D., F.A.G.D.

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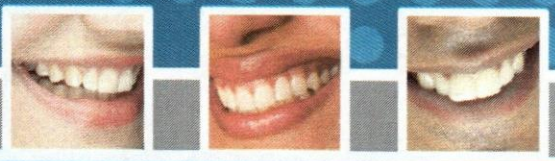

Patient Privacy Consent Form

☐ By checking this box, I acknowledge that I have read this statement and understand the contents.

The Department of Health and Human Services has established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to you personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with Dr. Burden.

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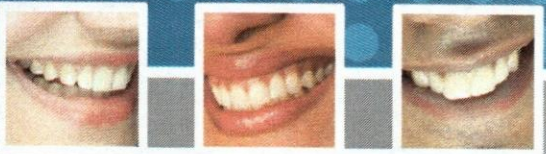

Consent for Dental Treatment

* ☐ TREATMENT

I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Dentures, Extractions, Impacted teeth removal, Root Canal Therapy, Implants, Treatment of periodontal disease, Dental risk assessments or other work deemed necessary.

* ☐ DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea, vomiting, or more severe allergic reactions. I have informed Dr. Burden of my known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

* ☐ RISKS OF ANESTHESIA

I understand that pain, bruising, and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue, or associated facial structures can sometimes occur with shots. The vast majority of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.

* ☐ FILLINGS

I understand that a more extensive restoration than originally planned, or possible root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature or biting pressure may occur after tooth restoration. I realize that fillings are rarely permanent and usually require periodic replacement with additional fillings and/or crowns at a later date.

* ☐ CROWNS, BRIDGES, INLAYS, AND ONLAYS

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify Dr. Burden of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final cementation. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment in this office or possibly by a specialist if complications or delays arise during treatment, and any costs thus incurred are my responsibility.

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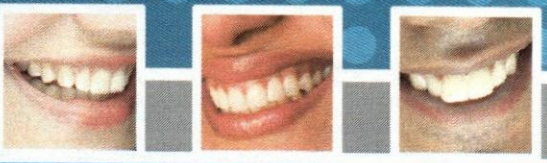

* ☐ DENTURES

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, that taste of foods may be altered, and that dentures are not permanent. I also understand that, while I no longer suffer from dental decay or periodontal infection as all of my teeth have been removed, I could experience denture related problems such as; shrinking of the gums, poor chewing ability, altered speech, reduced taste, and constant denture movement. Most denture wearers become used to these symptoms quickly while others take time. A small number of these patients never adapt to dentures. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for a number of days/weeks. Immediate dentures require frequent adjustments and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. If a remake is required due to my delay, additional fees may be incurred.

* ☐ EXTRACTIONS

Alternatives to tooth removal may include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of the bone, bone necrosis, and loss of feeling in my lip or other facial areas such as cheeks, tongue, gums, and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw if the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

* ☐ PERIODONTAL DISEASE

Periodontal disease is a serious condition leading to gum and bone infection and/or loss and may lead to loss of permanent teeth. There are currently many medical risks associated with untreated periodontal disease including stroke, heart disease, diabetes, low birth weight babies, and possibly dementia (Alzheimers disease). I understand that possible treatment plans have been explained to me. These plans can include scaling and root planning (deep cleanings), gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal disease treatment depends on my continuing meticulous home care and following Dr. Burdens instruction, including strict observance of periodontal maintenance appointments. I understand that care by a specialist may be necessary.

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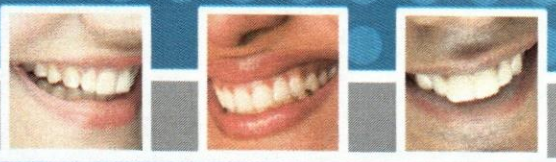

* ☐ ROOT CANAL THERAPY

I realize root canal therapy has a very high success rate, however, thee is no guarantee that root canal treatment will save a tooth and complications can occur. During the procedure, some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include extensive decay making the tooth non restorable, perforations, fractures, curved or hardened canal, or extra canals whose presence could not be diagnosed earlier leading to persistent pain and/or infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root which may or may not affect success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough may require further surgery or treatment by a specialist at additional cost to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed, which if not placed right away, may lead to fracture of the tooth and possible extraction.

☐ IMPLANTS I understand that implants may be a suggested treatment option to replace missing teeth, stabilize a denture, or to limit bone atrophy in certain regions of my mouth. If elected, I understand that implant treatments typically require two stages for completion. The first stage (fee) is for the implant placement and the second stage (fee) is for the prosthetic rehabilitation (denture or tooth). A period of 3-6 months can typically occur between these two phases of treatment.

* ☐ CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add or eliminate procedures because of conditions discovered during treatment that were not evident during examination. I authorize Dr. Burden to use professional judgment to provide appropriate care. I acknowledge that Dr. Burden will make every attempt to quickly notify me of changes to my plan as they become evident.

* ☐ CONSENT: I have had the opportunity to have all my questions answered by Dr. Burden, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with dental treatment. I hereby give my consent for the treatment I have chosen.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: *

Relationship to Patient:

*

Response Date: 6/17/2019