

Araceli E. Ziemba, DMD, LLC

drziemba.com

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(732)297-0588

Welcome to our Practice

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 Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City

State

Zip Code

May we confirm your appointments by Email? If Yes, please make sure you have filled in your email address above. * Yes No

Whom may we thank for referring you to our practice?

Referral Name: _____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: *

Employment Information:

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.

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

Name: _____
Last First MI Preferred Name

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

Birth Date: _____ SS#: _____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Secondary Dental Insurance

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Authorization:

* By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> *PreMed - Amox | <input type="checkbox"/> *PreMed - Clinda | <input type="checkbox"/> Ablation | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer | <input type="checkbox"/> Amoxicillin allergy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anti-Depressants | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> ArterialHypertension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Autistic | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Back Surgery |
| <input type="checkbox"/> Behavioral Disorder | <input type="checkbox"/> Biacin | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Breast Abscess | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bruises Easily |
| <input type="checkbox"/> Bypass - Coronary | <input type="checkbox"/> C PAP Machine | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac Ablation |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Celexa | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Cephalixin |
| <input type="checkbox"/> Chest Pain - Angina | <input type="checkbox"/> Childbirth | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Ciprofloxacin |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Colon Resection |
| <input type="checkbox"/> Cong.Heart Problems | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Covid | <input type="checkbox"/> Crohn's Dx |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Degen. Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Enlarged Pit. Gland | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Erythro Allergy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Flu Vaccine |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV | <input type="checkbox"/> Hashimoto | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Burn/Gerd | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Hyzaar Avalide | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Insulin Pump | <input type="checkbox"/> Iodine Allergy |
| <input type="checkbox"/> Irritable Bowel Synd | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Lichen Planus |
| <input type="checkbox"/> Lipitor | <input type="checkbox"/> Lobectomy | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Lung Transplant |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> MS | <input type="checkbox"/> Meniscus Root Repair |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mint | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Morphine Allergy | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> No Epi | <input type="checkbox"/> Nursing | <input type="checkbox"/> Nuts | <input type="checkbox"/> Oral Contraceptive |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Past Pregnancy |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Post Menopause |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Prolapsed Bladder | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Rash/Hives | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> STD | <input type="checkbox"/> Sarcoid | <input type="checkbox"/> See Chart |
| <input type="checkbox"/> Shellfish Allergy | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Smoker | <input type="checkbox"/> Stents |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Tetracycline allergy | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tramadol | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Valium | <input type="checkbox"/> Ventricular Bigeminy | <input type="checkbox"/> Wellbutrin |
| <input type="checkbox"/> Xerostomia/Dry Mouth | <input type="checkbox"/> Zthromax | | |

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * Yes No

Pre-Med:

Name of your physician and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin below:

Current Medications:

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Cardiovascular (Heart) *

- | | | |
|---|---|--|
| <input type="radio"/> Chest Pain (Angina) | <input type="radio"/> Congenital Heart Problem (CHP) | <input type="radio"/> Heart Attack |
| <input type="radio"/> Heart Murmur | <input type="radio"/> Heart Surgery: Bypass, Transplant, Stents | <input type="radio"/> High Blood Pressure (Hypertension) |
| <input type="radio"/> Irregular Heartbeat, Pacemaker (Arrhythmia) | <input type="radio"/> I take Aspirin Regularly | <input type="radio"/> Mitral Valve Prolapse |
| <input type="radio"/> Prosthetic/Artificial Heart Valve | <input type="radio"/> Rheumatic/Scarlet Fever | <input type="radio"/> Swollen Ankles |
| <input type="radio"/> Negative (None of the Above) | | |

Pulmonary (Lung)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema, Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> PPD Positive | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chronic Pulmonary Disease (CPD) | <input type="checkbox"/> Negative (None of the Above) | | |

Nervous System

- Alzheimer's Disease or other Dementia (schizophrenia)
- Degerative Disorders or Paralysis (Parkinson's, MS, Cerebral Palsy, Muscular Dystrophy, Bells Palsy)
- Depression, Phobias or Severe Anxiety Disorder
- Fainting/Dizziness
- Headaches, Frequent or Severe
- Psychiatric Care, ongoing nervous conditions
- Seizures/Epilepsy
- Stroke (CVA)
- Negative (None of the Above)

Hematologic (Blood)

- | | |
|--|--|
| <input type="checkbox"/> Anemia (not sickle cell) | <input type="checkbox"/> Bleeding Disorder (not hemophilia), post surgical |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bone Marrow or Stem Cell Transplant |
| <input type="checkbox"/> Bruises Easily | <input type="checkbox"/> Leukemia, Blood Cancer, Lymphoma, Multiplemyeloma |
| <input type="checkbox"/> Sick Cell Anemia/Trait Blood Disorder | <input type="checkbox"/> Negative (None of the Above) |

Gastrointestinal (Digestive)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Crohn's or Ulcerative Colitis | <input type="checkbox"/> Eating Disorders (Bulimia, Anorexia) |
| <input type="checkbox"/> Heart Burn, Reflux/GERD | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hepatitis D | <input type="checkbox"/> Hepatitis E |
| <input type="checkbox"/> Irritable Bowl Syndrome | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Transplant: Liver, Kidney or Other | <input type="checkbox"/> Ulcer (s) | <input type="checkbox"/> Negative (None of the Above) |

Genitourinary (Kidney's, Urinary)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney Disease or Failure | <input type="checkbox"/> Syphilis, Gonorrhea, Herpes | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Negative (None of the Above) | | | |

Endocrine

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Adrenal Disorder | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Prostrate Problem |
| <input type="checkbox"/> Thyroid Hyper | <input type="checkbox"/> Thyroid Hypo | <input type="checkbox"/> Negative (None of the Above) | |

Cancer

- | | |
|--|---|
| <input type="checkbox"/> Any history of cancer (breast, head, neck, prostate, oral, lung, skin, etc) | <input type="checkbox"/> Chemotherapy Treatment |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Negative (None of the Above) |

Musculoskeletal

- Artificial Joint (s)
- Degenerative Arthritis
- Osteoporosis
- Sinus Problems
- Weight Loss, Unexplained
- Negative (None of the Above)
- Bisphosphonates (Fosamax, Boniva or Actonel) for Osteoporosis
- Neck or Back Surgery/Pain
- Rheumatoid Arthritis
- Swollen Neck Glands
- Xerostomia/dry mouth

Immune System

- Allergy to Anesthetics
- Allergy to Medications (indicate below)
- Sjogren's Syndrome
- Cortisone Treatments
- Allergy to Foods, Metals, Jewelry
- HIV or AIDS
- Dermatology
- Retin A Treatments
- Allergy to Latex
- Lupus
- Rash, Hives, Sores
- Negative (None of the Above)

If you indicated that you are allergic to medications, please list below:

Drug Use

Alcohol Dependency

Prior or Current Injection Drug Use

Tobacco Use

Chemical Dependency

Prior or Current Non-Injection Recreational Drug Use

Negative (None of the Above)

Women

I am pregnant or possibly pregnant

I am nursing

Post-Menopause

Oral Contraceptive

Other Illness (please explain below)

Negative (None of the Above)

If you checked Yes for Other Illness, please explain below:

Dental Information

What is your immediate concern?

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam: _____ Date of most recent dental x-rays: _____

How often do you brush? * _____

How often do you floss? * _____

What changes in your smile would you make, if any?

Please check any of the following that apply to you now or previously: *

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Blisters on lips or mouth |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Cigarette, pipe, or cigar smoking |
| <input type="checkbox"/> Cleft lip or palate | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Fingernail Biting | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Grinding/Clenching Teeth |
| <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Implant Surgery | <input type="checkbox"/> Jaw Pain or Tiredness |
| <input type="checkbox"/> Lip or Cheek Biting | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Mouth pain when brushing | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Periodontal treatment/surgery | <input type="checkbox"/> Removable or fixed prosthesis/dentures/partials | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Sores, swelling or growths in mouth | <input type="checkbox"/> TMJ problems/pain | <input type="checkbox"/> Negative (none of the above) |

If anything checked above needs further explanation please explain below:

Consent for Services and Financial Policy

It is hereby understood and agreed that I, hereinafter referred to as "the Patient", Certify and shall be responsible for any and all charges incurred for Products and/or Services provided by Dr. Araceli E. Ziemba, DMD, hereafter referred to as "the Practice".

It is further understood and agreed that if the Patient fails to make payment as provided herein, a service charge of 5% per month may be charged to all unpaid balances due, and the Patient shall pay all costs and expenses, (including, but not limited to counsel fees and expenses) incurred in connection with all efforts and attempts to collect payment and we agree to them.

This Agreement shall remain in effect as long as the undersigned is a Patient of record, or as long as there is a remaining balance under the Patient's account.

*** By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

*** By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Name of patient, parent or guardian completing this form: *

Relationship to patient: *

Self Parent Guardian Other

Credit Card Payment Agreement

* I agree to pay Araceli E. Ziemba, DMD any deductibles and co-payments at the time services are rendered. I also agree that all charges that have not been paid by my insurance company are my responsibility. I hereby authorize Araceli E. Ziemba, DMD's office to charge to my credit card account the remaining balance, and/or any outstanding fees, if I have not paid within 30 days. If applicable, this agreement shall cover myself, my spouse, and any children.

Credit Card Information *

Visa MasterCard AMEX Discover CareCredit

Name on Credit Card:

Credit Card Number

Expiration Date:

Security Code: _____

Billing Zip Code:

Response Date: _____