HOWE DENTAL ASSOCIATES
15 HOWE AVENUE SUITE 2B
PASSAIC, NJ 07055
TEL 973-365-1931

FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:
1.Cash
2.Check
3.Credit Card -MC, AMEX, VISA, DISCOVER
4.Credit Card authorization for recurring charges:
    a. Treatment exceeds $200
    b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Patient not accompanying their child to an appointment must make PRIOR arrangements for payment (cash check, or credit card authorization).

Parents accompanying their children are financially responsible for payment.
18% annual interest is charged for any unpaid balance. A $15 fee is charged for nonpayment.
There is a $30.00 processing charge for **non- sufficient funds** or returned checks.
There is a nominal charge for release or copies of records.
Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$25-$50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, _____, agree to these financial terms.

Signature _____ Date _____

HOWE DENTAL ASSOCIATES

GENERAL CONCENT FORM

SECTION A: PATIENT INFORMATION

Patient Name:_____
Date of Birth_____
SSN:_____

SECTION B: CONSENT TO TREATMENT

I do hereby authorize and request the performance of dental services and the use of whatever procedures Dr. Weiner may deem necessary for treatment. I understand that Dr. Weiner and his staff will use clinical and patient management techniques that are reasonable, necessary, and advisable. I also authorize the administration of anesthetics or analgesics that may deem appropriate by Dr. Weiner. I understand that the purpose for using local anesthetics may be therapeutic, diagnostic, or for the treatment of facial pain. I understand that potential complications include, but are not limited to pain, swelling, bruising, temporary limited opening, and local infection. I understand that in occasional cases the anesthesia may be prolonged and in very rare cases permanent.

I understand that I am responsible for attaining any current x-rays that may have been taken at a previous office. If I do not obtain them, I permit the retaking of any necessary x-rays.

I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the examination and extend of dental pathology. Occasionally, once the treatment plan has been started, complications may arise that dictate additional procedures or treatment. Dr. Weiner, or his staff will always advise me of any changes.

In the event that Dr. Weiner , or his staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

SECTION C: SIGNATURE:

_____
Printed Patient/Guardian Name

_____ _____
Patient/Guardian Signature Date

For Guardians, please note your relationship to patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONCENT AFTER YOU SIGN IT.

HOWE DENTAL ASSOCIATES

MICHAEL WEINER, DDS
15 HOWE AVENUE, SUITE 2B, PASSAIC, NJ 07055
PH: 973-365-1931 | FX: 973-365-1590

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

DATE_____ Referred by_____

PATIENT ❑ Male

Patient's name_____ Birth date_____ Social Security #_____ ❑Female
If minor, parent's name_____ Home #_____ Cell #_____ Work #_____
Mailing address_____ City_____ State_____ Zip_____
Marital status ❑single ❑ married ❑ widowed ❑ divorced ❑ separated Spouse's name_____
Emergency contact_____ Relationship_____ Phone #_____

PRIMARY DENTAL INSURANCE ❑ NONE

Insurance Company Name_____ Group name_____ Group no._____
Subscriber's name_____ Birth date_____ Relationship to patient ❑ spouse ❑child ❑ other

SECONDARY DENTAL INSURANCE ❑ NONE

Insurance Company Name_____ Group name_____ Group no._____
Subscriber's name_____ Birth date_____ Relationship to patient ❑ spouse ❑child ❑ other

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial Joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑yes ❑no

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics (“Novocain”)
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants
- ❑ Antibiotic or sulfa drug
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetic drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ Pregnant
  Expected delivery date_____
- ❑ Taking hormones or contraceptives

Name of your physician:_____
Do you have any disease, condition, or problem not listed above? ❑ yes ❑ no
If yes, please explain:_____

Signature of patient (or parent)_____ Date_____