Connolly FAMILY DENTISTRY
Christopher J. Connolly, D.M.D, P.A.

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ M_____ Sex: ○M ○F

BIRTHDATE _____ AGE_____ Soc. Sec. #_____ Parent's/Guardian's Name _____

RESIDENCE Street _____ Apt. # _____ City _____ State_____ Zip_____

MAILING (If different from above) Street_____ Apt. #_____ City_____ ST_____ Zip_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

E-MAIL_____ I would like to receive text message appointment reminders ○ YES ○ NO

Who May We Thank for Referring You To Our Office? _____ Reason For This Visit _____

INSURANCE INFORMATION (PRIMARY)

POLICY HOLDER NAME Last _____ First _____ M_____ BIRTHDATE_____

Soc. Sec. #_____ (Most insurances require this for eligibility – Do **NOT** leave blank) OCCUPATION_____

Employer _____ Insurance Company_____

Insurance Company Address_____

Group #_____ Member ID #_____ (This could be Policy Holder's SS#) Local#_____

INSURANCE INFORMATION (SECONDARY)

POLICY HOLDER NAME Last _____ First _____ M_____ BIRTHDATE_____

Soc. Sec. #_____ (Most insurances require this for eligibility – Do **NOT** leave blank) OCCUPATION_____

Employer _____ Insurance Company_____

Insurance Company Address_____

Group #_____ Member ID #_____ (This could be Policy Holder's SS#) Local#_____

PATIENT NAME (PRINT) DATE OF BIRTH

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Patient Medical History

Emergency Contact Name_____Relationship_____Contact #_____

Physician_____Physician Address_____ Physician Phone_____

Pharmacy_____ Pharmacy Address_____ Pharmacy Phone_____

Are you under a physician's care now? ___Yes ___No If yes, please explain: _____

Are you taking any medications or prescriptions? ___Yes ___No Please list medicines: _____

_____

_____

Do you take or have you taken Fen-Phen/Redux? ___Yes ___No

Have you taken any medications containing bisphosphonates? ___Yes ___No

Do you use tobacco? (ie. Cigars, chew, and cigarettes) ___Yes ___No How long? _____

Women: Are you:

Pregnant/Trying to get pregnant? ___Yes ___No Taking oral Contraceptives? ___Yes ___No Nursing? ___Yes ___No

Are you ALLERGIC to any of the following?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Advil/NSAIDS

___Metal ___Latex ___Sulfa Drugs ___Erythromycin ___Nitrous Oxide

Other (please list):_____

Please indicate of the following which you have had or presently have:

Acid Reflux/G.E.R.D.	YES	NO	Congenital Heart Disorder	YES	NO	Low Blood Pressure	YES	NO
AIDS/HIV Positive	YES	NO	Diabetes	YES	NO	Lung Disease	YES	NO
Alzheimer's Disease	YES	NO	Drug Addiction	YES	NO	Mitral Valve Prolapse	YES	NO
Anaphylaxis	YES	NO	Emphysema	YES	NO	Osteoporosis	YES	NO
Anemia	YES	NO	Epilepsy / Seizures	YES	NO	Pacemaker	YES	NO
Angina	YES	NO	Fainting Spells / Dizziness	YES	NO	Psychiatric Care	YES	NO
Anxiety	YES	NO	Frequent Headaches	YES	NO	Radiation Treatments	YES	NO
Arthritis/Gout	YES	NO	Glaucoma	YES	NO	Respiratory Issues	YES	NO
Artificial Heart Valve	YES	NO	Heart Attack/Failure	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Artificial Joint	YES	NO	Heart Disease	YES	NO	Shingles	YES	NO
Asthma	YES	NO	Heart Murmur	YES	NO	Shortness of Breath	YES	NO
Back Problems	YES	NO	Hepatitis A	YES	NO	Sickle Cell Disease	YES	NO
Blood Disease	YES	NO	Hepatitis B / C	YES	NO	Sinus Problems	YES	NO
Blood Transfusion	YES	NO	Herpes	YES	NO	Stroke	YES	NO
Cancer	YES	NO	High Blood Pressure	YES	NO	Thyroid Malfunction	YES	NO
Chemotherapy with Cancer	YES	NO	High Cholesterol	YES	NO	Tonsillitis	YES	NO
Chest Pains	YES	NO	Irregular Heartbeat	YES	NO	Tuberculosis	YES	NO
Circulatory Problems	YES	NO	Kidney Problems	YES	NO	Ulcer/Colitis	YES	NO
Cold Sores/Fever Blisters	YES	NO	Liver Disease	YES	NO	Venereal Disease	YES	NO

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly FAMILY DENTISTRY
Christopher J. Connolly, D.M.D, P.A.

PATIENT DENTAL HISTORY

How long since you have seen a dentist? _____ Last cleaning?_____Last Full Mouth X-Rays?_____

Are you having problems now, please explain?_____

Is your present dental health poor?	YES	NO	Are your teeth sensitive to sweets/sours?	YES	NO
Do you wear dentures?	YES	NO	Are your teeth sensitive to pressure?	YES	NO
Are you happy with your dentures?	YES	NO	Do you have headaches, earaches, or neck pains?	YES	NO
Would you like to know more about permanent replacements?	YES	NO	Do you have discolored teeth that bother you?	YES	NO
Have you had any periodontal (GUM) treatments?	YES	NO	Are you unhappy with the appearance of your teeth?	YES	NO
Do your gums bleed, feel tender, or irritated?	YES	NO	Have you worn braces on your teeth (orthodontics)?	YES	NO
Are you aware of grinding or clenching your teeth?	YES	NO	Would you like your smile to look better or different?	YES	NO
Are your teeth sensitive to hot/cold?	YES	NO	Do you regularly use dental floss?	YES	NO

Rate your level of anxiety from 1-5 (five being the highest): _____

Rate your level of concern for dental cost from 1-5 (five being the highest): _____

Do you have any other concerns or information you would like the doctor to be aware of?:_____

_____

_____

Patient Name Patient Signature Date

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly FAMILY DENTISTRY
Christopher J. Connolly, D.M.D, P.A.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have been provided a copy of Christopher J. Connolly, DMD, PA's Notice of Privacy Practices, which has an effective date of 06/01/2018, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

Initial Below

x_____I hereby give my consent for Christopher J. Connolly, DMD, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Christopher J. Connolly, DMD, PA describes such uses and disclosures more completely.)

x_____With this consent, Christopher J. Connolly, DMD, PA may call my home or other alternative location and leave a message on voice mail, ***text message***, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, payments and any calls pertaining to my clinical care and treatment.

x_____With this consent, Christopher J. Connolly, DMD, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

x_____With this consent, Christopher J. Connolly, DMD, PA may ***e-mail*** to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

With this consent, I grant Christopher J. Connolly, DMD, PA permission to share my PHI (as outlined above) with

_____Relationship to patient: _____

_____Relationship to patient: _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices. By signing this form, I am consenting to allow Christopher J. Connolly, DMD, PA to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Christopher J. Connolly, DMD, PA may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's or Legal Guardian's Name Date

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly FAMILY DENTISTRY
Christopher J. Connolly, D.M.D, P.A.

Financial Policies

Thank you for choosing Connolly Family Dentistry as your dental health care provider. We are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental services available today. All of our practitioners and staff members pride themselves on the longstanding, positive relationships they create with our patients. Therefore, in order to assist you with your healthcare investment, to avoid potential misunderstandings and to allow you to always make the best choices related to your care, please review our office's financial policies. **Please initial and sign below where indicated.** We thank you for your understanding and cooperation.

Financial Responsibility:

Initial: _____ Full payment (including any co-payment, co-insurance and/or deductible) is due *at or before* the time services are rendered. Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications, laser therapy and any other services not directly provided by the dentist. We accept cash, check (existing patients of record only), Visa/Mastercard/Discover and Care Credit.

Minor Patients: The adult accompanying a minor and/or parent/guardian is responsible for full payment in accordance with our office's policies. For unaccompanied minors, non-emergency treatment will be denied unless payment by cash/check/credit can be made at the time the service has been scheduled/rendered.

At this time, full payment or a deposit is required to hold your appointment on all of our doctors' schedules.

Rescheduling Policy:

Initial: _____ It is the philosophy of our office to provide optimal, proactive patient care. All patients are therefore seen by appointment only and are scheduled with that patient's individual needs in mind. Time, trained personnel and dental equipment are reserved specifically for you for each procedure. It is very important for you to keep your scheduled appointments to properly complete your treatment and restore your overall wellness. Please help us serve you best by keeping your scheduled appointments.

We require **48 BUSINESS HOURS** advance notice to make <u>any</u> changes to an appointment. If appointments are broken/changed in less than 48 business hours, your account WILL be charged a $50 rescheduling fee **per hour** of reserved doctor and/or hygienist time. For example, if you have a 2-hour appointment on a Monday, we need to receive notice to reschedule *by Thursday at 5pm as the office is closed on weekends* to avoid a $100 rescheduling fee. Our voicemail/text messaging system cannot accept schedule changes so please be aware of our office hours to prevent the rescheduling fee charge. We have the right to charge the patient for the full cost of their missed appointment. All fees must be paid in full prior to scheduling any other appointments.

48 BUSINESS HOURS advance notice is necessary to allow us adequate time to notify patients who are on a waiting list for the next available appointment and to allow our clinicians to prepare for a different patient. We are then able to offer all of our patients the same exceptional standard of care.

Please note that the $50 new patient reservation deposit is also subject to the rescheduling policy and will not be refunded if appointments are broken/changed with less than 48 business hours advance notice.

PATIENT NAME (PRINT) DATE OF BIRTH

Insurance:

Initial: _____ Please remember, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We are not a participating provider. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. All estimates quoted, including pre-treatment estimates that come directly from your insurance company, are ESTIMATES ONLY-they are NOT a guarantee of payment. If you have any questions concerning the pre-treatment estimate and/or fees for services, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Ultimately, the patient is responsible for all charges incurred.

Please understand that it is physically impossible for us to have the knowledge of and/or keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

Our first priority is our patients. Therefore, your treatment plan is individually tailored to your health needs and lifestyle. It is not based on your dental insurance benefits or lack of benefits. Please be aware that some and possibly all of the services provided may be non-covered services. It is the patient's responsibility to know, understand and track their insurance benefits, deductibles and maximums.

Billing:

Initial: _____ Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member.

The balance on your account is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide all insurance information before your initial visit **and whenever your insurance changes**. If your insurance company has not paid their portion in full within 60 days of the claim being sent, the balance will automatically be transferred to your account.

Collections:

Initial: _____ Any account that has not received payment in 90 days will be referred over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office. All "referred" accounts will be marked inactive. In order to reactivate your account and be seen at our office, the full delinquent balance must be paid in full with cash or credit card.

Returned Checks:

Initial: _____ If any personal checks are returned by the bank for any reason, we require that the amount be immediately reimbursed by cash or credit. In addition to the original balance, you will be responsible to pay the $20 bank service charge assessed to our practice for returned checks.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's or Legal Guardian's Name Date

PATIENT NAME (PRINT) DATE OF BIRTH

Connolly FAMILY DENTISTRY
Christopher J. Connolly, D.M.D, P.A.

Media Release Authorization Form

I, _____, hereby authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's or Legal Guardian's Name Date

PATIENT NAME (PRINT) DATE OF BIRTH

Christopher J. Connolly, DMD, PA
379 Egg Harbor Road, Sewell, NJ 08080
856-582-0090

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 06/01/2018, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

PATIENT NAME (PRINT) DATE OF BIRTH

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

PATIENT NAME (PRINT) DATE OF BIRTH

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

PATIENT NAME (PRINT) DATE OF BIRTH

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Carmen Jackson
Address: 379 Egg Harbor Road
Telephone: (856) 582-0090
Fax: (856) 582-5747
Email: carmen@drcjconnolly.com

PATIENT NAME (PRINT) DATE OF BIRTH