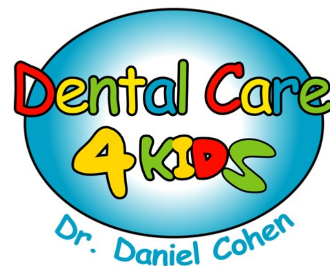
Welcome

Daniel Cohen, DDS
180 N. Dean Street, Suite 1 North
Englewood, NJ 07631
(201) 569-KIDS (5437)



Health History Form

Today's Date: ______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ________________________________
Last First MI

Goes by: ______________________ ☐ Male ☐ Female

Siblings that we treat ________________________________

Child's Birthdate _____/_____/_____ Child's Age ___________

School_____________________________Grade___________

Child's Home # (__________)________________________

SS#____

Child's Home Address:______________________________

____
City State Zip

Email Address:____________________________________

2. How did you hear about our office?

____

3. Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)___________________ Ext. __________

Home # (_________)___________________________________

Cellular Phone # (_________)___________________________

SS # ____________________ DL# ____________________

4. Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)___________________ Ext. __________

Home # (_________)___________________________________

Cellular Phone # (_________)___________________________

SS # ____________________ DL# ____________________

5. Who is Accompanying the Child Today?

Name ____

Relationship____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name____

Relationship____

Billing Address ______________________________________

____
City State Zip

Home # (___________)_________________________________

Work # (___________)_________________________________

Cellular # (___________)______________________________

E-mail ____

7. Primary Dental Insurance

Insurance Co. Name ___________________________________

Insurance Co. Address _________________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name ___________________________________

Relationship to Patient_______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ____________________________________

Policy Owner's Employer _______________________________

8. Secondary Dental Insurance

Insurance Co. Name ___________________________________

Insurance Co. Address _________________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name ___________________________________

Relationship to Patient_______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ____________________________________

Policy Owner's Employer _______________________________

9. Dental History

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ____________

Previous Dentist's Name_______________________________

Family Dentist's Name________________________________

Were any x-rays taken at previous dental visits? ____________

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain___________________________________

____

____

Why did you bring the child to the dentist today? ____________

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting   Y N Nail Biting

Y N Nursing / Bottle Habits   Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ___________________________________

____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes

Please discuss any serious medical conditions the child has had

____

____

Does the child have special needs? ______________________

Please list all drugs the child is currently taking ______________

____

Please list all drugs the child is allergic to __________________

____

Child's Physician ________________________________

Phone (____________)____________________________

Address:_______________________________________

____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____   ______________________
Signature of Parent or Guardian   Date   Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

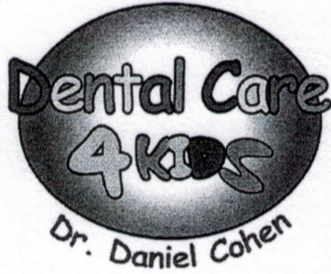
Initials ____________ Date ______________

Doctor's Comments ______________________________

____

____

____



Patient Name: ____

Authorization to Release Information:

I hereby authorize the above name dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims of benefits.

____ ______/_____/_____

Patient or Authorized Guardian's Signature

Authorization of Assignment of Benefits

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

____ ______/_____/_____

PAYMENT AND CANCELLATION POLICY
PLEASE READ CAREFULLY

**** Our office requires 24 hours notice for schedule changes. All appointments rescheduled or missed after this time will be charged. The charge will be $75 per missed appointment time. A courtesy call will be given prior to appointments, however please do not rely solely on this call. At times, phone lines are busy, machines are not left on or tape is full, or patients are difficult to get a hold of. Helping us keep your appointments and being on time will in turn help you.**

**** Payment is due at the time services are rendered. Co-pays are due at the time services are rendered. *** Insurance claims will be submitted as a courtesy by our office for you at the time treatment is completed. Any balances thereafter are the responsibility of the patient. Please be prepared to pay at the time of your appointment via cash, check, Visa, Mastercard, Discover and American Express, unless prior arrangements have been made. ****All accounts not paid within the billing cycle and that are past due are subject to finance charges based on an APR of 18% or 1.5% per month. The first month past due will be met with an additional $15 late fee to your bill.**

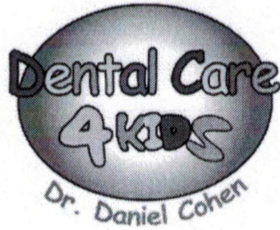
The undersigned patient hereby authorizes this practice to submit Insurance Carrier Claim Forms on behalf of the patient without further signature authorization. This form also authorizes the practice and/or patient to receive directly from the Insurance Carrier. All claim forms will be submitted with the notation "Signature on File". **I understand that although I have given insurance information, insurance is not a guarantee of benefits and I am responsible for my bill and any unpaid insurance claims.** I also understand that it is my responsibility to know what is covered by my insurance and not the responsibility of Dental Care 4 Kids.
An example of this is **Fluoride** treatment; some plans do not cover fluoride twice a year. Therefore, there may be a **copay** for this treatment.
I certify that the information given above is true and correct to the best of my knowledge.

I authorize Dental Care 4 Kids to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I also authorize any pre and post-op photos of my dental treatment to be used for any marketing and/or educational purposes. If my photos are chosen my identity will be concealed with my eyes being masked out of photos

The undersigned patient hereby agrees to the payment and cancellation policy stated above as well as the consent of use of treatment pre and post-op photos.

Child's Name ______________________________ **Date** ________________

Guardian Signature (if minor) ______________________________ **Date** ________________



CREDIT CARD AUTHORIZATION FORM

I, ______________________________, hereby authorize Dental Care 4 Kids to submit electronic claims on my behalf and agree to assign the payment directly to Dental Care 4 Kids. I understand that my dental benefit reimbursement plan is an agreement between my insurance carrier and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefit plan and any differences resulting from the amount billed, including estimated copayments already collected, and the amount covered by my plan.

I authorize Dental Care 4 Kids to debit my credit card account for payment of any account balance remaining on my account once the insurance check is posted or denied by the insurance company. If insurance payment is delayed longer than 30 days, I authorize Dental Care 4 Kids to debit my credit card account for any remaining balance on my account not paid by my insurance company.

____

PATIENT NAME DATE BILLING ZIPCODE

PLEASE CIRCLE CREDIT CARD: MASTERCARD VISA DISCOVER AMERCIAN EXPRESS

______________________________ ____/____ ____________________

CARD # EXP. DATE CC SECURITY CODE

______________________________________ ____________________

CARDHOLDER SIGNATURE TODAY'S DATE

____

PRINT NAME

CREDIT CARD INFO IS KEPT IN OUR CONFIDENTIAL FILES

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

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

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

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.

______________________________	______________________________
Please ***print*** name of Patient	Please ***sign*** for Patient / Guardian of Patient
______________________________	______________________________
Legal Representative / Guardian	Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ Work Phone Confirmation	☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation	☐ Text Message to my Cell Phone
☐ Home Phone Confirmation	☐ Email Confirmation
☐ Work Phone Confirmation	☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message	☐ **Any of the Above**
☐ Text Message	☐ **None of the above** (opt out)
☐ Email	

In signing this HIPAA Patient Acknowledgement 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.

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 (please describe) ____

____
Signature of Privacy Officer

HIPAA made EASY™
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