WELCOME!

Thank you for choosing Dental Care 4 Kids for your child's dental care!

Today's Date: _____

PATIENT INFORMATION

Name: _____ Nickname: _____DOB: _____Gender: Male/Female

Street Address: _____City: _____ State: _____ Zip: _____

Primary number for appointment confirmations: (_____) _____

Who is accompanying the child today? Name: _____ Relation: _____

****** Whom may we thank for referring you?** _____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN (I)

Name: _____ DOB: _____ SSN: _____ Gender: Male/Female

Marital Status: ☐Single ☐Married ☐Domestic Partnership ☐Separated ☐Divorced ☐Widowed

Home: (_____) _____ Cell: (_____) _____

Work: (_____) _____ Email: _____

☐ Check box if address is same as patient's listed above.

Street Address: _____City: _____ State: _____ Zip: _____

PARENT/GUARDIAN (II)

Name: _____ DOB: _____ SSN: _____ Gender: Male/Female

Marital Status: ☐Single ☐Married ☐Domestic Partnership ☐Separated ☐Divorced ☐Widowed

Home: (_____) _____ Cell: (_____) _____

Work: (_____) _____ Email: _____

☐ Check box if address is same as patient's listed above.

Street Address: _____City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

☐Check box if you gave us a copy of your insurance card(s) and skip to **Dental History.**

PRIMARY INSURANCE

Insurance Company Name: _____ ID#: _____ Group#:_____

Insurance Address: _____ Phone: _____

Name of Insured: _____ Employer: _____

DOB: _____ SSN: _____

SECONDARY INSURANCE

Insurance Company Name: _____ ID#: _____ Group#:_____

Insurance Address: _____ Phone: _____

Name of Insured: _____ Employer: _____

DOB: _____ SSN: _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? _____

Has the child ever been to the dentist? ☐YES ☐NO

(If yes) Previous/Present Dentist: _____ Date of last exam/x-rays: _____

Has the child had any orthodontic treatment? ☐YES ☐NO

Do you think your child will react well to treatment? ☐YES ☐NO

DENTAL HABITS

☐ Suck Thumb/Finger ☐Suck/Bite Lips ☐Bite/Chew Nails ☐Tongue Thrust

☐Bottle/Breast Feed ☐Use Pacifier ☐Clench/Grind Teeth ☐Mouth Breather

HYGIENE ROUTINE

☐Fluoride Toothpaste/Mouthwash ☐Consume Fluoridated Water ☐Take Fluoride Supplements

☐Brushing: _____/day ☐Flossing: _____/day ☐ Snacks: _____/day

MEDICAL HISTORY

Are immunizations current? ☐YES ☐NO

Child's Physician: _____ Phone: _____ Date of Last Exam: _____

Current Medications: _____

History of Hospitalizations/Operations/Emergency Room Care/Recent Illnesses: _____

Pre-medication needed? ☐YES ☐NO Reason: _____

Has your child been diagnosed and or treated for any of the following:

☐ Blood Disorder/Anemia
☐ Abnormal Bleeding/ Hemophilia
☐ Asthma
☐ Cancer/Tumor/Leukemia
☐ Heart Murmur/Defect/Surgery
☐ Epilepsy/Seizures/Convulsions
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Kidney/Liver Problems
☐ Diabetes
☐ HIV/AIDS
☐ ADD/ADHD
☐ Autism Spectrum
☐ Vision Problems
☐ Hearing Problems/Deaf
☐ Mental/Cognitive/Social Delay
☐ Speech Problem
☐ Eating Disorder
☐ Latex Allergy
☐ Drug Allergy: _____
☐ Food Allergy: _____
☐ Other: _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Dental Care 4 Kids NJ may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Dental Care 4 Kids NJ all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Parent/Guardian Signature: _____ Date: _____

OFFICE POLICY

FINANCIAL: <u>PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.</u> 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, VISA, MASTERCARD, DISCOVER and AMEX. 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% monthly cycle. The first month past due will be met with an additional $15 late fee to your bill.

APPOINTMENTS AND CANCELLATIONS: Our office requires 24 hours' notice for schedule changes. All appointments rescheduled, missed and or cancelled after this time will be charged. The charge will be $75 per appointment time. Repeated cancellations or missed appointment will result in loss of future appointment privileges.

**** I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT NOT PAID BY INSURANCE. I HAVE READ AND UNDERSTAND MY FINANCIAL OBLIGATION TO DENTAL CARE 4 KIDS. ****

Patient Name: _____

Signature: _____ Date: _____

<u>HIPAA OMNIBUS RULE</u>

NOTICE OF PRIVACY PRACTICES:** By signing below I acknowledge that I have received and reviewed a copy of the office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities and healthcare operations as set forth in this office's Privacy Policy. ***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 **<u>PRINT</u>** NAME OF PATIENT

PLEASE **<u>PRINT</u>** NAME OF GUARDIAN/LEGAL REPRESENTATIVE

_____ _____

SIGNATURE OF GUARDIAN/LEGAL REPRESENTATIVE

RELATIONSHIP OF GUARDIAN/LEGAL REPRESENTATIVE

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: _____

Credit Card #: _____ **EXP DATE** _____/_____

CVV CODE: _____ **Please Circle: VISA/MASTERCARD/DISCOVER/AMEX**

CARD HOLDER NAME: _____ **BILLING ZIPCODE:** _____

CARD HOLDER SIGNATURE: _____ **DATE:** _____