

WELCOME!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo # _____

City State Zip

General Information

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

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone: (____) _____

Relative or Friend not living with you:
Name: _____ Phone: (____) _____

Address: _____
City State Zip

Parent's Information

Who is responsible for account? _____ Parent's Marital Status

Father Step Father Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

Single Married Partnered Widowed Divorced Separated

Mother Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

CONTINUED ON BACK

Dental & Medical History

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

Has the child ever taken any diet pills such as Phen-Fen? Yes No
 (Also known as Redux or Pondimin.) If so, when? _____

Is the child currently in pain? Yes No

Does the child require antibiotics before dental treatment? Yes No

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

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/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

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Please describe the child's current physical health:
 Good Fair Poor

Please list all prescription / over the counter or supplement drugs that the child is currently taking:

Aside from the items listed, please list all drugs/things that the child is allergic to:

Y N Latex Y N Metals/Nickel Y N Plastic

Has the child experienced the following medical problems?

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV+ | <input type="checkbox"/> Y <input type="checkbox"/> N Hives/Skin Rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays/Operations? | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Low/High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Measles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Mononucleosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions | <input type="checkbox"/> Y <input type="checkbox"/> N Prosthetics |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Exposed to HIV, but Neg. | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Are the child's immunizations current? Yes No

Anything you would like to discuss with the Doctor in private? Yes No

Please discuss any serious medical problems the child experiences/ed:

Does/did the child experience any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Breast Fed | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chewing on Objects | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clenching/Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue/Cheek Biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Used Pacifier |

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

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

 Signature of Dentist

 Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? Y N
 If Yes, please explain. _____

 Parent/Guardian Signature

 Date

 Dentist Signature

 Date

Has there been any change in your child's health status since their last visit? Y N
 If Yes, please explain. _____

 Parent/Guardian Signature

 Date

 Dentist Signature

 Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

*Section A: **Patient Giving Consent***

Name: _____

Address: _____

Telephone: _____ SS#: _____

*Section B: **TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENT***

Purpose for Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care options.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice, at any time.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

University Dental PC
43-07 214th Place
Bayside, New York 11361
718-225-0515

Silverman & Gott, L.L.P
2592 Merrick Road
Bellmore, NY 11710
516-781-9700

Office Policy

It is our goal to provide you with the highest level of dental care possible. We are committed to both improving your current health, and preventing future dental problems.

We must make our treatment recommendations based on the best available option to you.

Unfortunately, most dental insurance companies provide coverage only for what they deem to be the minimally accepted standard of care. We therefore will in no way allow insurance benefits to dictate treatment.

Due to clinical situations, a proposed treatment plan may change. We will inform you of any changes in treatment as they occur, and of any changes in your financial responsibility.

All Dental work requires a non-refundable down payment of 50% and the balance must be paid two weeks before completion of the treatment.

For our insured patients, your co-payment and deductible are due at the time of service. **The amount of co-payment quoted is based on the best information we have available at the time of the estimate.** When we receive payment from your insurance company, we will make any necessary adjustments, and you will be charged for any remaining balance.

For non-insured patients, your full payment is due at the time of your visit, unless other arrangements have been made in advance. If payment arrangements are not kept as agreed, the original arrangement will be forfeited and payment in full will be expected at time of service. No exceptions.

For any and all senior citizen discounts, payment must be made in full at time of service unless otherwise specified.

All appointments are exclusively reserved. Therefore, a 24 hour advance notice is required if you need to cancel or change this appointment. We reserve the right to charge a fee without sufficient notice.

Our office charges \$40 for returned checks.

Any outstanding balance over 60 days will incur finance charges. If the balance remains unpaid, your account may be forwarded to collection and any fees incurred will be added to your account.

To insure timely receipt of all payments, we request that all patients leave a credit card on file with their consent. We reserve the right to apply to that card any balances due on you and/or your family account.

.....
Please apply any balance to the following credit card:

Visa _____ Mastercard _____ American Express _____ Discover _____

Credit Card Number _____

Expiration Date _____ Security Code _____

Billing Address of Credit Card _____

I have read all the information listed above and agree to comply with all office policies.

Print Name

Signature

Date

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Authorization for Use of Signature On File for Claim Authorization

Subscriber Social Security Number

Subscriber Name

I, _____, authorize _____
Patient/Subscriber Name Provider Name

to mark the section "Subscriber's" or "Authorized Person's" signature with the notation:
"Signature on File."

This section authorizes:

- 1) The release of any medical information necessary to process all claims.
- 2) Payment of dental/medical benefits to the above provider of service.

This authorization will remain in effect until terminated in writing by the enrollee.

Subscriber/Patient Signature

Date

NO-SHOW / LATE CANCELLATION POLICY

Silverman & Gott Family Dentistry is committed to meeting all of our patients' health care needs.

Please be advised of the following policy:

All appointments must be cancelled by 3pm of the previous day (or by 2pm on the Saturday before a Monday appointment) to avoid incurring a no-show or late cancellation fee being charged to you.

PLEASE NOTE: Insurances do not cover no-show or late cancellation fees so the patient will be responsible for payment.



NO-SHOW / LATE CANCELLATION fee of \$50 will be charged to you if an appointment either is missed, or not cancelled by 3pm on Monday-Friday or 2pm on Saturday of the previous business day.

Patient (or Responsible Party) Signature

Date