Date: _____

Patient Information

Child's Name: _____ DOB: _____ Age: ____
Last Name First Name

Nickname: _____ Gender Identity: _____ Pronouns: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home: _____ Parent Cell/Work: _____

Referral Information

How did you hear about us? _____

Responsible Party Information

Name: _____ DOB: _____
Last Name First Name

Gender Identity: _____ Pronouns: _____ Social Security #: _____-_____-_____
Email Address: _____
Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home: _____ Cell: _____

Dental Insurance Information

Primary

Name of Insured: _____ Relationship to Insured: _____
Last Name First Name

Name of Employer: _____
Insured's Birth Date: _____ID #: _____Group #: _____

Insurance Company: _____

Insurance Co. Phone #: _____ Do you have secondary coverage? _____

Secondary

Name of Insured: _____ Relationship to Insured: _____
Last Name First Name

Name of Employer: _____

Insured's Birth Date: _____ID #: _____Group #: _____

Insurance Company: _____

Insurance Co. Phone #: _____

In Case of Emergency Contact

Name of Contact: _____
Last Name First Name

Patient's Relationship to Contact: _____ Best Phone # to reach: _____

Reverse Side →

Medical/Dental History (Check the boxes that apply)

☐ Artificial Heart Valve	☐ Hepatitis A, B, C, D, E	☐ Oral Herpes
☐ Artificial Joints	☐ AIDS/HIV	☐ Chemical Dependency
☐ Pacemaker/Defibrillator	☐ Autism	☐ Jaundice/Liver Disease
☐ Organ Transplant	☐ Headaches	☐ Ulcer
☐ High Blood Pressure	☐ Sinus Problems	☐ Thumb/Finger Sucking
☐ Low Blood Pressure	☐ Back Problems	☐ Blood Thinners
☐ Heart Problems	☐ Hemophilia	☐ Circulatory Problems
☐ Thyroid Disease	☐ Cancer/Leukemia	☐ High Cholesterol
☐ Stroke	☐ Radiation Treatment	☐ Breathing Problems
☐ Hemophilia	☐ Respiratory Disease	☐ Asthma
☐ Epilepsy	☐ Diabetes	☐ Other: _____

Does your child have any of the following? If yes please list, or explain

Allergies to Anesthetics: _____

General Allergies: _____

Allergies to Medicine/Drugs: _____

Have you ever had an adverse reaction to any dental treatment? YES ☐ NO ☐

If yes please explain. _____

Are you allergic to latex? YES☐ NO☐

Does your Physician require you to take antibiotics prior to dental treatment? YES ☐ NO☐

Are you under the care of a physician? _____

Please List Medications/doses you are currently taking:

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Name of Medicine: _____ Dosage: _____

Is there anything else we should know about your medical history? _____

_____

When was your child's last dental cleaning? _____

Is your child's water fluoridated? Yes☐ No ☐

Does your child brush his/her teeth daily? Yes☐ No ☐

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature: _____Date: _____

Reverse Side ⟶

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPPA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of 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 healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information, and of other important matters about you protected health information. A copy of Our Notice accompanies this consent. 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 that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Jillene Dye. Telephone #: (732) 951-0099

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. 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.

Our Policy: Missed appointments without cancellation will result in a $35 charge. To avoid being charged please cancel your appointment 24 hours prior to your appointment.

Consent: I give consent to the following people to have access to my information below that I have checked off. Check all that apply.

Dental Records ☐ **Health History** ☐ **Referrals** ☐

Treatment Plan/Options ☐ **Insurance Information** ☐ **Account Information** ☐

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

☐ _____ **I DO NOT CONSENT**
(initial here)

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*

Reverse Side →

Dentistry at South Brunswick and Your Insurance Plan – How They Work Together?
Our Office Financial Policy

The staff at Dentistry at South Brunswick is pleased that you have insurance assistance to help with the cost of your dental care. We would like to help you obtain the maximum use of your dental plan benefits. Please read the following information on our insurance claims process so that we can work together to ensure this assistance.

Do You Accept My Insurance? How Much Will They Pay?

We currently accept all private care insurance plans (plans that do not *require* you to select a dentist from a pre-determined list). We estimate your portion based on the most up-to-date information on your plan, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment.

I Thought I Paid My Portion But I Received A Bill. Why?

We base the patient portion of your bill on our most current information on your dental plan, but there are many factors that can affect this estimate. There may be an individual or family deductible or you may have received treatment in another office which is not calculated into our database. Sometimes you may need to be referred to a specialist for care, which also is applied to your annual maximum benefits. Insurance companies do not notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

Insurance Didn't Pay, Now What?

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Dentistry at South Brunswick reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. It is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Financial Options

Dentistry at South Brunswick requests payment in full for your portion (co-pay) at the time of service. We accept cash, check, MasterCard, American Express, Discover, and Visa. If you are in need of an extended finance option, we also work with Care Credit, Chase Healthcare Advance, and Capital One. They offer plans up to 24 months with no interest, depending on your treatment plan needs. Just ask our Financial Coordinator Jill and she will give you everything you need.

We welcome you and your family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dentistry at South Brunswick.

_____

Signature *Date*

Reverse Side →