welcome

PATIENT NUMBER

Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced❑ Widowed ❑ Minor ❑

Residence—Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient /Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Present Position _____

How Long Held _____

Who is Responsible for this Account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit ❑

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or Policy # _____

Social Security No. _____

Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or Policy # _____

Social Security No. _____

Union Local or Group _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing the statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by me dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIANS SIGNATURE

_____

DATE _____

REGISTRATION

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Nickname Date of Birth

Parent's / Guardian's Name _____

DENTAL HISTORY—CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? . . . YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? . . . YES NO
4. Does your child eat between meals? . . . YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? . . . YES NO
6. When does your child brush his/her teeth?
   ❑ Upon arising ❑ After eating any food ❑ Right after meals ❑ Before going to bed
7. How does your child receive Fluoride?
   ❑ Community water level _____ ppm ❑ Well water level _____ ppm
   ❑ Fluoride drops or tablets ❑ Fluoride rinse or gel
8. Have any cavities been noted in the past? . . . YES NO
9. Were any teeth (baby or permanent) removed by extraction? . . . YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc. . . . YES NO
    If so, describe _____
11. Has your child had any problem with dental treatment in the past? . . . YES NO
12. Has anyone in the family, including parents, had orthodontics? . . . YES NO
13. Has your child ever received a local anesthetic? . . . YES NO
14. Has your child ever had occlusal sealants? . . . YES NO
15. Does your child think there is anything wrong with his/her teeth? . . . YES NO

MEDICAL HISTORY

1. Does your child have a health problem? . . . YES NO
2. Is your child under care of a physician? . . . YES NO
   If yes, since when and why? _____
   Phone
3. Name of physician? _____
4. Is your child receiving any medication? . . . YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? . . . YES NO
6. Is your child allergic to or sensitive to any metals or latex? . . . YES NO
7. Does your child have any other allergies? . . . YES NO
8. Has your child had any serious illness? . . . YES NO
   When _____ What _____
9. Has your child ever had surgery? . . . YES NO
10. Does your child have a heart murmur? . . . YES NO
11. Is surgery contemplated? . . . YES NO
12. Does your child experience severe or prolonged bleeding? . . . YES NO
13. Does your child have AIDS or has he/she tested HIV positive . . . YES NO
14. Has your child tested positive for hepatitis? . . . YES NO
15. Is your child subject to nervous disorders? . . . YES NO
16. Does your child have frequent headaches? . . . YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'SSIGNATUR _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

PEDIATRIC
DENTISTRY and ORTHODONTICS
of Midland Park

Financial Agreement & Insurance Facts

Patient Name(s): _____

It is the policy of this office to make complete payment arrangements at the time of your visit. This may be handled in one of the following ways:

1) If you have dental insurance, we may verify your coverage as a courtesy prior to your visit. However, it is not the responsibility of our office to know your insurance plan. It is your responsibility to know your coverage and to notify the front desk of any changes. We will submit to your insurance if possible and any remaining balance will be your responsibility. We are **ONLY in network with Delta Dental Premier Plans**, not with Delta PPO or any other carriers. This means that unless your insurance carrier honors our contract with Delta Dental Premier, **all fees are only estimated** and you may or may not have a balance after your insurance pays and possibly even after your deductible and copays are met. For basic and/or major dental procedures, even Delta Premier Plans may leave a balance on the account.
   In addition, some dental services may or may not be covered by your insurance. For instance, fluoride and sealants may only be covered up to a certain age and emergency or problem-focused exams may be grouped into your annual exam limit. Also, most insurance companies will not cover cleanings and exams if they are not exactly 6 months and day since your last check-up. Coming prior to that day may result in a denial of coverage.
2) **If you do not have dental insurance, payment is expected at the time the services are rendered.** If you would like to arrange for a monthly payment plan to be billed directly to a credit card, we would be happy to make arrangements for you.

By signing below as a legal guardian for the minor receiving services, I agree to the following:

- I authorize the dentist to perform diagnostic procedures, which may include x-rays, and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning me (or my child/children's) healthcare, advice and treatment to my insurance company for the purpose of administering claims and also to another dentist, if necessary.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I recognize that there will be a fee of $25 for all checks returned due to insufficient funds.
- I consent to this office contacting me by phone, text, or email in reference to any appointments and/or my account.
- I understand that my child/children's dental insurance carrier may pay less than the actual bill for services. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or employer. The dentist is not a party to this contract. Therefore, I understand that I am fully responsible for the payment of all sums on all of my accounts in this dental office for services, treatments, procedures and/or diagnostic methods provided to me or my child/children. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental insurance carrier.

Patient Or Guardian's Signature: _____

Print name: _____

Relationship to Patient:_____ Date: _____