Welcome!

Edgewater Pediatric Dentistry
725 River Road, Suite 204A
Edgewater, NJ, 07020
201.313.KIDS(5437)

Tell Us About Your Child

Today's Date:______________ Child's Home Phone #: ____________________ Social Security #:______________________________

Child's Name: ____ Child's Birthdate: _______________ Child's Age: _______
Last First MI

Nickname: _________________________ ❑ Male ❑ Female School: ______________________________ Grade:__________

Child's Home Address: ____
Street City State Zip

Whom may we thank for referring you? ____________________ Email Address: _____________________________________

Emergency Contact Name: ________________________ Phone #: ___________________ Relationship #: _____________________

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single ❑ Partnered

Mother Birthdate: ___________ Home #: ___________________ Work #: ___________________ Cell #: ____________________

Name: _________________________________ Social Security #: _____________________ Driver's License #: _________________

Address: ____
Street City State Zip

Employer: _________________________________ Occupation: ______________________ Length of Employment:_____________

Father Birthdate: ___________ Home #: ___________________ Work #: ___________________ Cell #: ____________________

Name: _________________________________ Social Security #: _____________________ Driver's License #: _________________

Address: ____
Street City State Zip

Employer: _________________________________ Occupation: ______________________ Length of Employment:_____________

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ____________________ Phone #: ____________________ Group # (Plan, Local, or Policy #):_______________

Insurance Co. Address: ____
PO Box/Street City State Zip

Insured's Name: ____ Relationship to Patient: ___________________________

Insured's Birthdate: _______________ Social Security #: ___________________ Insured's Employer: ___________________________

Employer's Address: ____
PO Box/Street City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ____________________ Phone #: ____________________ Group # (Plan, Local, or Policy #):_______________

Insurance Co. Address: ____
PO Box/Street City State Zip

Insured's Name: ____ Relationship to Patient: ___________________________

Insured's Birthdate: _______________ Social Security #: ___________________ Insured's Employer: ___________________________

Employer's Address: ____
PO Box/Street City State Zip

CONTINUED ON BACK

Dental History

Is the child currently in pain? ❑ Yes ❑ No **What is the primary reason for today's visit?** ____________________

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

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

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: ____________________ Date of last visit: ____________
(Please Circle)

Does / did the child have any of the following habits?

❑ Lip Sucking / Biting	❑ Clenching / Grinding Teeth	❑ Tongue / Cheek Biting	❑ Mouth Breather
❑ Nail Biting	❑ Thumb / Finger Sucking	❑ Used Pacifier	❑ Speech Problems
❑ Chewing on Objects	❑ Nursing Bottle Habits	❑ Tongue Thrust	❑ Breast Fed

Medical History

Child's Physician: ____________________ Phone #: ____________ Date of last visit: ____________

Address: ____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: ____________________

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

Please list all drugs that the child is currently taking: ____________________

Besides the following, please list all drugs and/or things that cause the child allergic reactions:

Latex? ❑ Yes ❑ No Metals/Nickel ❑ Yes ❑ No Plastic? ❑ Yes ❑ No Penicillin? ❑ Yes ❑ No Tetracycline? ❑ Yes ❑ No

____

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

Has the child had/experienced any of the following:

❑ Abnormal Bleeding	❑ Chicken Pox	❑ Heart Murmur - Innocent	❑ Mitral Valve Prolapse
❑ ADHD	❑ Cleft Lip/Palate	❑ Heart Murmur - Premed	❑ Mononucleosis
❑ AIDS / HIV+	❑ Congenital Heart Defect	❑ Hemophilia	❑ Psychiatric Problems
❑ Allergies	❑ Convulsions	❑ Hepatitis	❑ Rheumatic Fever
❑ Anemia	❑ Diabetes	❑ High Blood Pressure	❑ Scarlet Fever
❑ Any Hospital Stay / Operations	❑ Down Syndrome	❑ Hives	❑ **Seizures**
❑ Asthma	❑ **Epilepsy**	❑ Kidney Problems	❑ Sickle Cell Anemia
❑ Autism	❑ Frequent Headaches	❑ Liver Problems	❑ **Skin Rash**
❑ Blood Transfusion	❑ Handicaps / Disabilities	❑ Low Blood Pressure	❑ **Tonsillitis**
❑ Cancer	❑ Hearing Impairment	❑ Lupus	❑ Tuberculosis (TB)
❑ Cerebral Palsy		❑ Measles	

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

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Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Nguyen and the dental team to examine, clean and provide dental treatment on my child's teeth. I further authorize the taking of dental x-rays as may be considered necessary by Dr. Nguyen to diagnose and/or treat my child's dental problem. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

____
Signature Date

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OUR FINANCIAL POLICY

We accept the following forms of payment for dental treatment – Cash, check, MasterCard, Visa, American Express and third party financing (CareCredit). Full payment is due at the time of service unless other arrangements are made in advance.

Regarding Insurance

It is our policy to provide the best dentistry to you. To do this, it is important that we do not allow dental benefits to be a determining factor in diagnosis. Your treatment will be based upon your values and needs.

The term "dental insurance" is misleading. What is commonly known as "dental insurance" is more correctly termed **dental benefits.** Dental benefits are not intended to pay everything, but to assist with the costs of dental treatment. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by which plan your employer has purchased. **Your insurance policy is a contract between you and your insurance company.** We are not a party to that contract.

YOUR FINANCIAL OBLIGATION

As a **courtesy** to you, we will submit claims to your dental plan carrier. Your co-pay and deductible are due the day of service. In order to submit your insurance we need accurate information from you. If your claim is denied or we do not receive anticipated reimbursement for the balance of your claim within 30 days we will resubmit ONCE. If we have no response within 2 weeks, we will invoice you for all unpaid balances. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. Accounts not paid within terms and are sent to collection are subject to a $50.00 collection fee.

Please be aware of our cancellation and broken appointment policy; we reserve the right to charge a minimum fee of $50.

I have read, understand, and agree to the above financial policy.

Print Name___________________________

Signature_____________________________ Date_________________
Patient/Guardian

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 Surname ☐ 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

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WEB and SOCIAL MEDIA PHOTO RELEASE FORM

☐ Edgewater Pediatric Dentistry ***has my permission to post photographs of me within their dental practice and/or on their website, social media accounts, videos, or slide show presentations, print ads and all other marketing or advertising efforts that promote their dental practice.***

☐ **I decline to authorize Edgewater Pediatrc Dentistry to post photographs of me/my child at this time.**

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Patient's Name

______________________________________ ________________________
Signature of Parent/Guardian **Date**

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Cancellation Policy

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that if you need to cancel your scheduled appointment, please notify us at least 24 hours in advance allowing the vacancy to be filled with someone needing the appointment.

The following is our policy regarding missed and cancelled appointments:

- Appointments missed without notification of the office will be billed a $50.00 fee for the reserved time. This fee may be waived if it is determined by the doctor.
- Consistent "no shows" may be refused future appointments.
- "Late shows" may be rescheduled if determined by the office staff.

These fees are not covered by insurance carriers and will be your responsibility to pay at the time of your next visit.

OUR AIM IS TO OPEN OTHERWISE UNUSED APPOINTMENTS FOR OUR PATIENTS, NOT TO COLLECT MISSED APPOINTMENT FEES.

Your cooperation and consideration are appreciated as we institute this policy.

I have read, understood, and agree to the terms of this policy as it is stated.

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Patient Name (please print)

____ ______________

Signature of Parent (Guardian) Date