Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's / Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's / Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Caring Dentistry for Children
259 Baldwin Road
Parsippany, NJ 07054
973-541-9992

OUR POLICY ON BROKEN APPOINTMENTS

Caring Dentistry for Children would like you to be aware that unlike some offices, we do not overbook our appointment schedule. We are committed to giving you the time and attention you deserve and require, to meet your dental needs. We hold your appointment exclusively for you.

We confirm as a courtesy to our patients whenever possible. We know that you have busy schedules and that **your time is just as valuable as ours.** It is however, your responsibility to make note of the date and time of your appointments and to commit to keeping them as scheduled so that we can complete your treatment effectively.

We are aware that **Medical** emergencies can arise suddenly and can prevent you from keeping your appointments. Fortunately, these are infrequent occurrences. In these rare instances we ask that you notify us immediately so that your appointment may be made available should a patient call on an emergent basis.

If you find that other needs require you to cancel your scheduled appointment we require 24-hour notification. Appointments that are cancelled or are not kept, with out the requisite notice will be charged $50.00.

We thank you for your understanding and commitment to assist us in providing you and our other patients with the most effective dental care possible.

I have read, understand, and accept the appointment policy.

_____Date_____
Patient or Authorized Representative

Caring Dentistry for Children
Benjamin Lopkin, DMD
259 Baldwin Road
Parsippany, NJ 07054

Caring Dentistry for Children

OUR FINANCIAL POLICY

We are committed to providing your children with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD (S) FOR YOUR FILE.

- COPAYMENTS — By law we MUST collect your carrier designated co-pay at the time of service. Please be prepared to pay that co-pay at each visit.
- NON CO-PAY PLANS — If your plan does not require co-pay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates in their explanation of benefits.
- NON-PLAN PATIENTS — Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.

Most insurance plans do not cover composite restoration on posterior teeth 100%. In these cases, the balance between what the insurance covers and the designated fee will be your responsibility.

Individual insurance plans vary greatly. Our office will confirm your benefits prior to your appointment. If you have any questions, please ask.

You are responsible for the timely payment of your account.

Accounts unpaid over 90 days will be forwarded to collections. Any and all fees that may be associated with the collection of unpaid accounts will be your responsibility including, but not limited to, all attorney's fees.

WE ACCEPT CHECKS, CASH, AMEX, MASTERCARD, OR VISA.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

RESPONSIBLE PARTY SIGNATURE_____ DATE_____

Caring Dentistry for Children
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have read a copy of this office's Notice of Privacy Practices. **(Posted on the wall next to front door)**

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)
