



Evan Hershkowitz, DDS, MPH
Seven Seas Pediatric Dentistry
1001 Route 376
Wappingers Falls, NY 12590
(845) 214-0008

NEW PATIENT FORMS

Patient Information:

First Name: _____	Last Name: _____	
Sex/Gender: _____	Preferred Name: _____	
Address: _____		
City: _____	State: _____	Zip: _____
Birth Date: _____	Age: _____	

Parent/Guardian Information:

First Name: _____	Last Name: _____	
Address: _____		
City: _____	State: _____	Zip: _____
Primary Phone Number: _____	Secondary Phone Number: _____	
Birth Date: _____	E-mail Address: _____	

Insurance Information:

Primary Insurance Company: _____	Plan: _____
Name of Policy Holder: _____	Employer: _____
Date of Birth: _____	Social Security Number: _____
Secondary Insurance Company: _____	Plan: _____
Name of Policy Holder: _____	Employer: _____
Date of Birth: _____	Social Security Number: _____

Referral Information:

Referred By: _____
Reason for Referral: _____

Medical History

Has the patient been to a dentist in the past? Please circle: Yes / No

If yes, for what reason and date of last visit: _____

Is the patient currently taking any medications or need to premedicate? Please circle: Yes / No

If yes, please list: _____

Does the patient have any allergies or adverse reactions to any of the following:

Please circle: None Latex Penicillin Amoxicillin Local Anesthetics Other

If other, please list: _____

If the patient is under the care of any physicians, please list them in the chart below:

Type of Physician	Doctor's Name	Office Phone Number

Has the patient had any of the following conditions? Please circle yes or no below for each:

ADD/ADHD	Yes / No	Emotional Problems	Yes / No
Asthma	Yes / No	Epilepsy/Seizures	Yes / No
Autism Spectrum Disorder	Yes / No	Heart Condition	Yes / No
Behavioral Problems	Yes / No	Immunologic Disorder	Yes / No
Bleeding Disorder	Yes / No	Kidney Disease	Yes / No
Cancer	Yes / No	Leukemia	Yes / No
Chemotherapy	Yes / No	Liver Disease	Yes / No
Delayed Development	Yes / No	Psychiatric Problems	Yes / No
If yes, approx age:	_____	Scarlet Fever	Yes / No
Diabetes	Yes / No	Sensory Problems	Yes / No
Down's Syndrome	Yes / No	Sickle Cell Disease	Yes / No

Please list any additional past or current medical conditions if not listed above:

Parental Guidelines

Dear Parents,

We want you and your child to receive the best possible treatment at our office. We feel this is a joint process in which the parents will play a pivotal role. Dental offices perform both non-invasive and invasive procedures at the same time in the treatment area. Your child's regular check-ups are considered non-invasive, while dental surgery and operative are considered invasive.

As a parent we know how much time you've spent in your child's physicians office and we, as dentists, share some similarities with them; most notably seeing several patients throughout the day for non-invasive procedures. The most notable difference is that a physician will perform their invasive surgeries in an outpatient setting or a hospital where only staff and doctors are present. A dentist performs his surgical and operative procedures in the same area and at the same time as our non-invasive patients are seen. The dentist requires the same level of concentration given to the physician in their controlled environment. Minimum movement and distractions in and about the operative area are crucial for optimal care of the children. You can assist us by following a few guidelines:

- Allow us to prepare your child.
- Be supportive of the practice's terminology.
- Please be respectful of our staff as we are respectful of you.
- We welcome you to come back to the Treatment Area for your child's visit. However, there are occasions where you will be asked to leave the room for the safety of yourself and your child, such as when taking x-rays. One of our staff members will be with your child at all times.
- You are responsible for remembering your child's appointment and arriving on time. If you are late by 15 minutes or more, the appointment will have to be rescheduled. We will give you a courtesy reminder call 1-2 days before your scheduled appointment at the phone number you provided us with. If you need to reschedule or cancel your appointment, please give us at least 24 hour notice. With 3 appointments missed (no call/no show) you will not be able to rebook and will receive a letter of dismissal from the practice.

Financial Agreement

If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and copayments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Seven Seas Pediatric Dentistry.

In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. As a courtesy, we will file your insurance benefits for you after every visit. However, please realize that the relationship is between you, the insured, and your insurance company. If we do not receive payment from your insurance company within 30 days after submission of claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed.

Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your portion in full at the time of service.

Parent/Guardian Signature

Date

Medical/Dental Release Statement

I give my consent for Dr. Evan Hershkowitz of Seven Seas Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Seven Seas Pediatric Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Hershkowitz and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Requirement for Filing Insurance Claims: To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30-days of treatment. I hereby authorize payment of insurance benefits directly to Seven Seas Pediatric Dentistry. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in attempt to collect on this amount.

Parent/Guardian Signature

Date

HIPAA Consent Agreement (Privacy Act)

You may refuse to sign this agreement.

I give consent for the Use and Disclosure of Health Information of myself and/or my dependent for the purpose of Treatment, Payment, or Communication between other healthcare professionals.

I understand and have been provided with a copy of this office's Notice of Privacy Practices that provides a more complete description of health information uses and disclosures.

I understand that I have the right to review a copy of this office's Notice of Privacy Practices prior to signing this consent.

Parent/Guardian Signature

Date