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# New Patient Forms

## *Patient Information*

First Name:_____ Last Name:_____

Sex/Gender:_____ Preferred Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____

## *Parent/Guardian Information*

First Name:_____ Last Name:_____

Cell Phone:_____ Secondary Phone:_____

Date of Birth:_____ Email:_____

Address (if different than child):_____

City:_____ State:_____ Zip:_____

## *Insurance Information*

Primary Insurance Company:_____ Plan:_____

Name of Policy Holder :_____ Employer: _____

Date of Birth:_____ ID Number or SSN:_____

Secondary Insurance Company:_____ Plan:_____

Name of Policy Holder :_____ Employer: _____

Date of Birth:_____ ID Number or SSN:_____

## *Pediatrician Information*

Name:_____ Phone Number:_____

## *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: Latex / Penicillin / Amoxicillin / Local Anesthesia / Other / None
If other, please list: _____

If the patient is under the care of a specialist, please list them in the chart below:

| Type of Specialist | Name of Doctor | Office Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

Does the patient have or has had any of the following conditions?
Please circle **YES** or **NO** for **each condition** listed below:

| | | | |
|---|---|---|---|
| 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 | Immunological 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 in years:* | _____ | 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 current or past medical conditions if not included above:

_____

_____

_____

_____

## Parental Guidelines

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 physician's 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 and 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 10 minutes or more, the appointment must be rescheduled. Please see the following Office Attendance Policy page for more information.

## 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.

We ask that you pay your portion in full at the time of service. 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.

_____ _____

Parent/Guardian Signature Date

# Office Attendance Policy

Please understand all of our appointments are scheduled in 30 minute increments. We allow a 10 minute grace period for your appointment. Arriving after this does not allow Dr. Evan or our hygienists an adequate amount of time to complete treatment without inconveniencing the families scheduled after you. If you arrive after the 10 minute limit your appointment will need to be rescheduled to another day. We are a small office with only one dental provider and because of this it is very important that families arrive to appointments on time.

When arriving we also ask that you come directly to the front desk and check your child in immediately.

## No Shows and Cancellations

We understand there are going to be days where you are not able to make it to your child's appointment. We ask that you call our office as soon as possible and let us know about any appointments that need to be rescheduled or canceled. Our voice mail is available 24/7 and is checked every morning and afternoon. Canceling appointments ahead of time allows us to use those open slots for families on our waiting list and keeps our schedule running as efficiently as possible.

There will be a $20 charge for missed appointments.

After 2 no-shows in a row we will not schedule any appointments for your child and a dismissal letter will be mailed to you.

We do allow families with multiple children to book those appointments on the same day. However, after 2 canceled appointments families with multiple children will be forced to separate appointments to prevent having continuously large gaps in the schedule.

## Confirmation Calls

Remembering appointment dates and times are your responsibility as parents/guardians.

Our office will give you a courtesy reminder call 1-2 days before your child's scheduled appointment. Please update your contact information with us so that we have current and working phone numbers available. Not receiving a reminder call is not a valid excuse for no-showing or arriving late to appointments.

_____ _____

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 an 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.

If this consent is not signed, we are unable to send dental records to other doctor offices.

_____ _____

Parent/Guardian Signature Date