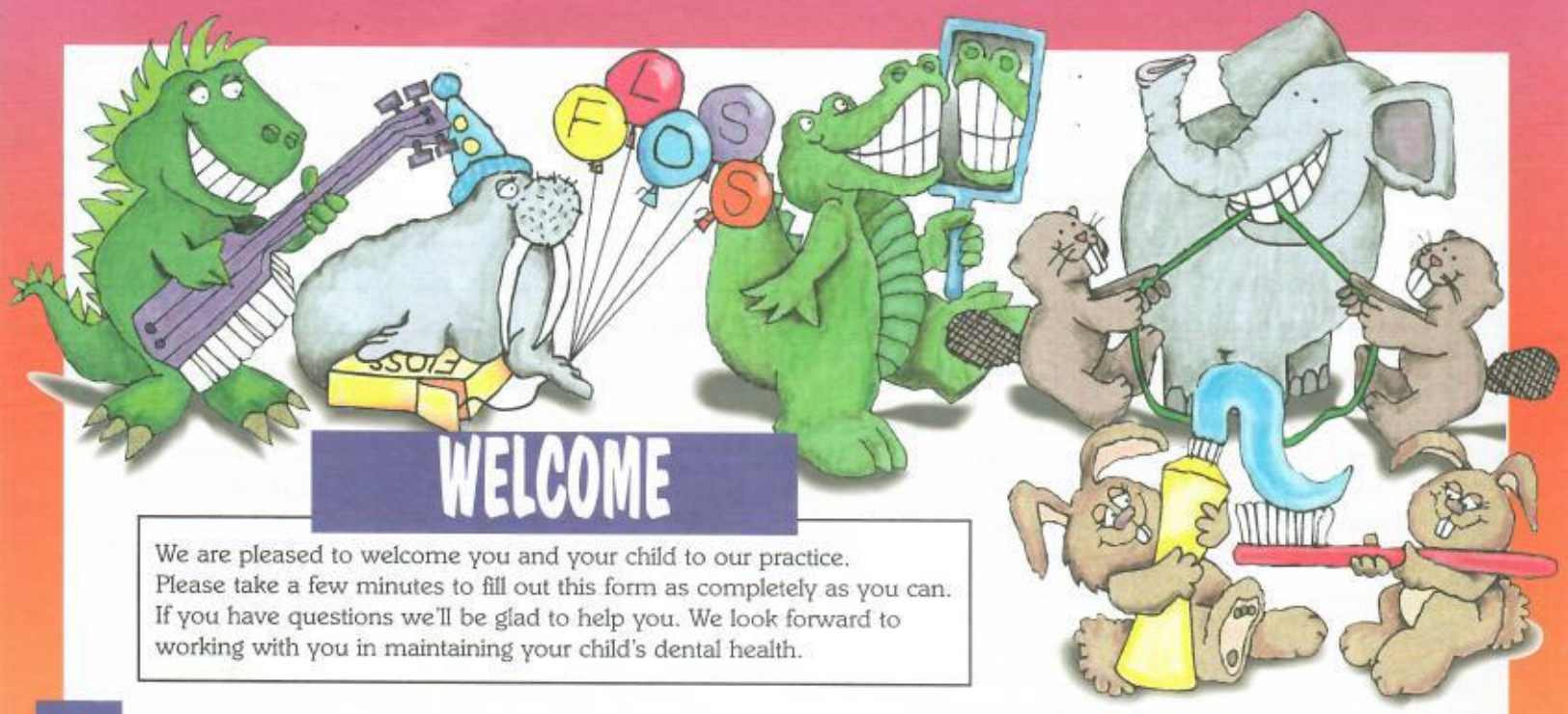

WELCOME

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 _____ Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

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

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home (____) _____ Work (____) _____
(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 (____) _____ Work (____) _____
(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
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐

	YES	NO
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
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?	☐	☐	Medications _____
Receiving any medication or drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	_____
Ever had surgery?	☐	☐	Allergies _____
Is there excessive bleeding when cut?	☐	☐	_____

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 (____) _____

AUTHORIZATION

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 _____

Name of Insurance Company(ies)

and assign directly to 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 _____

Complaints

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your conflict, you may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in this notice.

By the way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patients Name (print)

_____ _____

Patient's Signature/Guardian's Signature Date

_____ _____

Authorized Facility Signature Date

Pediatric Office Policies

1. We require at least 24 hours advance notice for appointment cancellations. Effective as of January 1, 2014, there will be a $75.00 charge for cancellations made within 24 hours of your scheduled appointment. If there are 2 broken appointments we reserve the right to charge a missed appointment fee of $75.00. More than 3 broken appointments may result in patient termination.

2. We reserve the right to reschedule an appointment for patients arriving more than (15) fifteen minutes late.

3. In the event that the patient's insurance coverage changes, please have the courtesy to call us ahead of time so we can provide adequate information and not delay treatment for your child or other patients.

4. **If nitrous oxide (laughing gas) is not covered by insurance and is used during the procedure there will an $100.00 fee, which must be paid at the scheduled appointment**.

5. **If oral sedation medication has been recommended, and is not covered by insurance, there will be a $225.00 fee, which must be paid at the scheduled appointment**.

6. ALL Coinsurance for any general anesthesia case MUST be paid 7 days in advance of the scheduled appointment.

7. All dental procedures that are not covered by your insurance (Private insurance or all state Medicaid plans) will have to be paid by the responsible party. Please review your dental benefits booklet carefully as each insurance company may have different coverage schedules.

8. In the case of divorce, custody, adoption, and/or guardianship issues, whichever parent/guardian brings the child to his/her dental appointment, that parent or guardian will be financially responsible for payment of co payments and deductibles regardless of who holds the insurance.

9. **There will be a $70.00 fee for all returned checks**.

10. If the parent/guardian is not the one bringing the child to the dental appointment, a handwritten note consenting to treatment MUST BE SENT OR WE CANNOT SEE THE CHILD.

11. Please be aware that a number of insurance providers are now bundling routine procedures such as x-rays into the patient's deductible. This means that even though it may be a covered service, the responsible party will have to pay for that procedure if the deductible has not been met.

My signature below acknowledges that I understand the office policies of this dental office. I further understand that my child's dental treatment is conditioned on the above policies. It is further understood that "we" refers to the dental offices of Dr. James L. Goldsmith.

_____
Date

_____
Patient's Parent or Legal Guardian's Signature

_____
Patient's Parent or Legal Guardian's Name (Print)