



## PEDIATRIC DENTISTRY OF UNION

### Tell us about your child :

Child's Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Male  Female  Non-Binary

Birthdate: \_\_\_\_\_

Child's home address, town & zip code:

\_\_\_\_\_  
\_\_\_\_\_

### Who is accompanying the child today?

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Do you have legal guardianship of this child?

Yes  No

Who may we thank for referring you?

\_\_\_\_\_  
\_\_\_\_\_

Other siblings seen by our office:

\_\_\_\_\_

### Parent / Guardian Information

Parent Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Birthdate: \_\_ / \_\_ / \_\_\_\_

Home# \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Occupation: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Birthdate: \_\_ / \_\_ / \_\_\_\_

Home# \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Occupation: \_\_\_\_\_

E-Mail: \_\_\_\_\_

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

### Primary Dental Insurance

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_ / \_\_ / \_\_\_\_

Policy Owner's SSN: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Policy ID #: \_\_\_\_\_

Insurance Co Group #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

### Secondary Dental Insurance

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_ / \_\_ / \_\_\_\_

Policy Owner's SSN: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Policy ID #: \_\_\_\_\_

Insurance Co Group #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

I understand the information that I have given is accurate to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any changes.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# PEDIATRIC DENTISTRY OF UNION

## DENTAL HISTORY

Why did you bring your child to the dentist today?  
\_\_\_\_\_

Is this your child's first dental visit? \_\_\_\_\_ Y N  
If not, how long since the last dental visit?  
\_\_\_\_\_

Were any X-rays taken at your child's previous dental visits? \_\_\_\_\_ Y N  
Have cavities been noted in the past? \_\_\_\_\_ Y N  
Has your child had any difficulty with previous dental work? \_\_\_\_\_ Y N  
If yes, please explain:  
\_\_\_\_\_

Were any teeth removed by extraction?  
Have there been any injuries to teeth such as falls, chips, etc.? \_\_\_\_\_ Y N  
If yes, please explain  
\_\_\_\_\_

Has your child ever received local anesthetic? \_\_\_ Y N  
Has your child ever had occlusal sealants? \_\_\_\_\_ Y N  
Does your child think there is anything wrong with his/her teeth? \_\_\_\_\_ Y N  
Does your child eat between meals? \_\_\_\_\_ Y N  
Does your child eat sweets such as candy, soda, gummies? \_\_\_\_\_ Y N  
Does your child brush his/her teeth?  
Upon arising      After meals      Before bed  
Does your child receive Fluoride?  
Community water/ Well water/ Fluoride Vitamins  
Does your child suck his/her thumb or fingers? \_\_\_ Y N  
Anything you would like to discuss with the doctor in private? \_\_\_\_\_ Y N

## MEDICAL HISTORY

Does your child have a health problem? \_\_\_\_\_ Y N  
If yes, please explain \_\_\_\_\_

Child's Pediatrician:  
Phone #: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Is your child currently taking any medications? \_\_\_ Y N  
Please List Medications:  
\_\_\_\_\_

Is your child allergic to penicillin, antibiotics, or ANY other drugs? \_\_\_\_\_ Y N

Is your child allergic to: Latex      Metals/ Nickel  
Does your child have any other allergies? \_\_\_\_\_ Y N

Has your child had any serious illness? \_\_\_\_\_ Y N  
When \_\_\_\_\_ What: \_\_\_\_\_

Has your child had surgery? \_\_\_\_\_ Y N  
Does your child have a **heart murmur**? \_\_\_\_\_ Y N

Does your child experience severe or prolonged bleeding? \_\_\_\_\_ Y N

Does your child have AIDS, or have they tested HIV positive? \_\_\_\_\_ Y N

Has your child tested positive for hepatitis? \_\_\_\_\_ Y N  
Is your child on the Autism Spectrum? \_\_\_\_\_ Y N

Is your child subject to nervous disorder? \_\_\_\_\_ Y N  
Fainting      Seizures      Dizziness

Does your child have behavioral and/or learning difficulties? \_\_\_\_\_ Y N

Does your child have frequent headaches? \_\_\_\_\_ Y N

**Has your child had a history of:** (circle all that apply)  
diabetes, cardiac problems, asthma, kidney problems, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, cognitive disability, eye problems, cancer, infections, speech impairments, hearing loss.

Are you child's **immunizations** current? \_\_\_\_\_ Y N

I understand that the information that I have given is accurate to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes to my child's medical status.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



## PEDIATRIC DENTISTRY OF UNION

### CONSENT FOR DENTAL TREATMENT

I consent to the diagnostic procedures and dental treatment deemed necessary by the dentists at Pediatric Dentistry of Union, for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### CANCELLATION POLICY

Dear Parents,

As parents ourselves we recognize that unforeseen circumstances often occur with children. These circumstances force us to cancel and reschedule appointments. Please understand that with each dental appointment time has been specifically set aside for your child/children. If you are unable to keep your scheduled appointment time we kindly ask that our office be notified a minimum of 24 hours in advance. This will make the time available for other children.

Repeated cancellations or failure to show up for appointments will result in a rebooking fee of \$50.00 per child that will be collected prior to rescheduling their appointment.

We recognize that your time is valuable and we ask that you respect that ours is as well.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

#### OFFICE USE ONLY

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An Emergency situation prevented is from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_



**PEDIATRIC DENTISTRY  
OF UNION**

---

**Understanding Dental Insurance**

We have prepared this letter to help our patients understand the complexities of dental insurance. We realize how confusing it can be. **To begin, we would like to highlight a misconception: dental insurance is NOT designed to pay for all your dental care.** Most contracts have yearly limits, treatment limitations and/or various degrees of “co-payments”.

Our fees are based upon a combination of our costs, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Our office participates with several different dental insurance companies as both a contracted provider or “in-network” and non contracted provider “out of network”. Our doctor's treatment recommendations are based on their clinical findings and not based on what your insurance company allows. How you proceed with treatment is ultimately your decision.

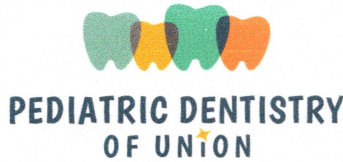
**Please understand the dental insurance contract is between the insurance company and the patient.** Our office does submit all claims for treatment provided to your insurance company on your behalf. If you are unclear as to whether a particular procedure is covered by your insurance carrier, please contact them directly with any questions. For further clarification you may request our office submit a predetermination on your behalf. Predeterminations are used as a tool to determine plan coverage; however it is **NOT a guarantee of plan payment.**

We hope this information has been helpful. Please take the time to review your insurance policy thoroughly so that we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

---

I certify that my child is covered by the insurance company provided and I assign directly to Pediatric Dentistry of Union all the insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Notice of Privacy Practices**

**Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.**

**The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. By signing the acknowledgment of receipt of our privacy practice, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.**

By signing the Acknowledgement of receipt of notice of privacy practice, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

**We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.**

**Our Privacy Official: Mouli Patel, DMD Telephone: (908) 686-2082 Fax: (908) 686-2149**

**Address: 381 Chestnut Street. Union NJ 07083 Email: info@pdofu.com**