PEDIATRIC DENTISTRY
OF UNION

**Tell us about your child:**

Child's Name: _____

Nickname: _____

☐ Male ☐ Female ☐ Non- Binary

Birthdate: _____ Age: _____

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 or patient 18 or older Signature _____ Date: _____

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**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**

Are you child's immunizations current?_____Y N

Does your child have a **heart murmur**?_____Y N

If yes, please provide Cardiologist Name and Number

_____

Does your child have a health problem?_____Y N

If yes, please explain _____

Child's Pediatrician Name: _____

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 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

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Parent / Guardian or patient 18 or older Signature _____Date:_____

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## 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 or patient 18 or older Signature _____ Date _____

## ACKNOWLEDGEMENT OF HIPPA

I, _____ have received a copy of this office's notice of privacy practice. **(HIPPA)**

## PHOTO RELEASE

I, grant my permission for **Pediatric Dentistry of Union** to post photographs and/or videos of my child(ren) on their website and/or social media accounts for promotional and educational purposes.
Child(ren)'s Name(s): _____

_____

Parent/ Guardian or patient 18 or older signature _____

Date: **(check box if you REFUSE the photo release)** ☐

## 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 charge of $50.00 per child.
We recognize that your time is valuable, and we ask that you respect that ours is as well.

Parent / Guardian or patient 18 or older Signature _____ Date _____

## Informed Consent for Text Message's and Email's

Your dental care is important to us. To provide you and your family with the best possible care, our office sends convenient text messages & emails to our patients about their dental care.
The mobile number(s) & email address(s) associated for Pediatric Dentistry of Union can be found below:

(908) 686-2082 & (470)407-6588

noreply@fromyourdentalprovider.com & info@pdofu.com

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.

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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: _____

PEDIATRIC DENTISTRY
OF UNION

# 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**