CENTER SQUARE
FAMILY DENTAL
NISHIT SHAH, DMD

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Swedesboro, NJ 08085
www.CenterSquareDental.com

Child's Registration and Medical History

Your child's complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 About Child

Today's Date:_____

Name:_____
LAST FIRST MI

Nickname:_____ ❑ Male ❑ Female

Birthdate:__/__/__ Age:_____ SS #:_____

Home Address:_____
APT / CONDO #

_____
CITY STATE ZIP

Home #: (___)_____ Cell #: (___)_____

Where and when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

2 Parent Information

Father's Name:_____

Birthdate:__/__/__ Age:_____ SS #:_____

Employer:_____

Home #: (___)_____ Cell #: (___)_____

Work #: (___)_____ Ext:_____ DL #:_____

Mother's Name:_____

Birthdate:__/__/__ Age:_____ SS #:_____

Employer:_____

Home #: (___)_____ Cell #: (___)_____

Work #: (___)_____ Ext:_____ DL #:_____

Person Responsible for Account:

Work #: (___)_____ Ext: ____ Home #: (___)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer:_____ DL #: _____

ARE YOU ON MEDICAID?..... ❑ YES ❑ NO

DO YOU HAVE DSHS COUPONS?..... ❑ YES ❑ NO

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

I hereby assign payment of dental benefits otherwise payable to me directly to Center Square Family Dental, LLC.

Signature: _____

In the event of an emergency, who should be notified, other than a parent?

Name:_____ Relation:_____

Work #: (___)_____ Home #: (___)_____

4 Medical History

Does your child have a personal physician?..... ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Is the child currently under the care of a physician?..... ❑ Yes ❑ No

Please Explain: _____

4 MEDICAL HISTORY continued

Date of last physical:_____

Child's current physical health is:..... ❑ Good ❑ Fair ❑ Poor

Is child taking any prescription, over-the-counter, or supplement drugs? ❑ Yes ❑ No

Please list each one:_____

_____

Does your child smoke or use tobacco in any other form?.....❑ Yes ❑ No

Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

- ❑ Aids or Other Immunosuppressive Disorders
- ❑ Allergies to Anesthetics
- ❑ Allergies to Medicines or Drugs
- ❑ Asthma
- ❑ Artificial Heart Valves or Joints
- ❑ Bladder Problems
- ❑ Cerebral Palsy
- ❑ Chemical Dependency
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Hearing Problems
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis, Jaundice, or Liver Disease
- ❑ Kidney Problems
- ❑ Mononucleosis
- ❑ Radiation Treatment
- ❑ Rheumatic Fever
- ❑ Thyroid Problems
- ❑ Tuberculosis

Please list any serious medical condition(s) that your child has had:

_____

_____

Is your child allergic to any of the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry/Metals
- ❑ Latex
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other

Please list any other drugs/materials that child is allergic to:_____

_____

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

When was child's last dental visit?_____

Experiencing any discomfort now?_____

Do you desire complete dental service for your child?_____

Has your child ever responded adversely to medical or dental treatment?

_____

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work?.....❑ Yes ❑ No

Is there anything else we should know about child's dental history?_____

_____

How many times a week does child floss?_____

How many times a day does child brush?_____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

_____

Relationship to child

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: Date:

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____
2. Date: _____ Comments: _____ Signature: _____
3. Date: _____ Comments: _____ Signature: _____

CENTER SQUARE
FAMILY DENTAL

MINOR CONSENT POLICY

Our office prides itself on offering top notch care, but the best treatment can only be provided when our doctors and our patients and their families work as a team.
Please familiarize yourself with the following office policies to make your next visit with us the best it can be.

We expect that all patients come to their appointment with one parent/guardian. If a parent/guardian cannot attend the appointment, then a Minor Appointment Consent Form should be completed that allows another adult over the age of 18 years old, who fully understands the patient's medical history, and who can make all treatment decisions for the patient with/without consulting with the parent/guardian to attend the appointment in lieu of the parent/guardian. If applicable, for every appointment that a parent/guardian cannot attend this form needs to be re-completed

While we would certainly prefer that a parent or guardian attends the appointment, we understand that sometimes a grandparent or caregiver may be bringing your child for treatment. We will happily treat your child, but the legal parent or guardian, prior to the appointment, must sign all consent forms. If a caregiver is accompanying your child to his or her appointment, kindly call our office in advance so we can assure the proper consent forms are signed and payment arrangements are made. If consent is not given in advance, we will have to reschedule your child's appointment.

I have read and understand this document in its entirety, outlining office and financial policies. Without reservation, I agree to abide by the policies outlined herein.

_____

Print Name of Parent/Guardian

_____

Signature of Parent/Guardian

_____

Date

CENTER SQUARE
FAMILY DENTAL

Appointment Cancellation Policy

When our office books your appointment, we are saving dedicated chair time just for you. We ask that if you must reschedule your appointment, that you please provide us with at least 48 hours notice. This courtesy makes it possible to give your reserved time slot to another patient.

If you fail to provide sufficient notice to the office or fail to show for your appointment, there will be a $50 charge.

By signing this form, you are agreeing to the terms and conditions of our office appointment cancellation policy.

_____ _____

Patient Signature Date

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Our Policy Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility, we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that **you are responsible for the total treatment fee**. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost.

In order for us to obtain your insurance information for submiting your claim and/or discuss your situation directly with your insurance we will need your authorization.

Please Initial:

_____ I have read and understand the above information.

_____ I authorize release of any information relating to my claim.

_____ I authorize payment directly to **Center Square Family Dental, LLC.**

_____ I understand that all fees not paid by insurance are my responsibility.

_____ _____

(Print Name) Date

_____

Signature

CENTER SQUARE
FAMILY DENTAL

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. In addition, we are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

_____ _____

(Please Print Name) **Date**

_____

(Signature)

Office Use Only

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

Patient Name: _____

- ❑ Individual Refuses to Sign
- ❑ Communication Barriers – prohibited obtaining the acknowledgement.
- ❑ Emergency Situations– prevented us from obtaining the acknowledgement.
- ❑ Other – please explain: _____

_____ _____

Staff Signature **Date**