Children's Dental Center of Monmouth, PA

...where caring hands care for your children...

2 Apple Farm Rd, Red Bank, NJ, 07701
Phone: (732) 671-1266 Fax: (732) 671-2166

Please fill in the personal history on the following pages. This information is an important aid in making a thorough evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs.

THIS MATERIAL IS STRICTLY CONFIDENTIAL

Patient Information

Date _____
Child's Name _____
Nickname _____
Age _____ Birthdate _____
Address _____

_____

Town _____ Zip Code _____
Phone _____
Mother's Name _____ DOB _____
Social Security No. _____
Mother Employed By _____
Phone _____
Father's Name _____ DOB _____
Social Security No. _____
Father Employed By _____
Phone _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

How did you hear about us?

_____

Email Address _____

Dental Insurance

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship *Date*

Dental History

Is this the child's first visit to the dentist? ☐ Yes ☐ No
Date of last visit and reason _____
Name of Dentist _____
How often does your child brush his/her teeth? _____
Do you assist? ☐ Yes ☐ No
Has your child ever had dental x-rays? ☐ Yes ☐ No
Date _____
Where _____
Are you seeking complete dental care for your child? ☐ Yes ☐ No
Explain _____
Does Mom or Dad have any history of cavities? ☐ Yes ☐ No
Explain _____

Has your child ever injured their head, mouth and/or teeth? ☐ Yes ☐ No
Explain _____
Is your child having any dental problems now? ☐ Yes ☐ No
Explain _____
Has your child had any unfavorable dental experiences? ☐ Yes ☐ No
Explain _____
Does your child take a bottle to bed at night? ☐ Yes ☐ No
What is in the bottle? _____
Age of child when they completely stopped using the bottle
Has your child had any teeth removed? ☐ Yes ☐ No
Explain _____
Does your child take flouride in any form now? ☐ Yes ☐ No
How _____

Does your child have a history of: (if yes, please check)

☐ Thumbsucking ☐ Pacifier Use ☐ Cheek Biting ☐ Speech Problems
☐ Nail or object biting ☐ Tongue Thrusting ☐ Tooth Grinding ☐ Mouth Breathing

How do you think your child will react to dental treatment? _____

_____

•OVER•

Medical History

Child's Physician _____

Phone _____

Are all immunizations up to date? ☐ Yes ☐ No

Condition of child's health _____

Date and reason for last examination by physician _____

_____

Was pregnancy and delivery normal? ☐ Yes ☐ No

If no, please explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain _____

_____

Has your child ever had general anesthetic? ☐ Yes ☐ No

If yes, please explain _____

Is your child allergic to any medication? ☐ Yes ☐ No

If yes, list all medications _____

_____

Are there any other allergies? ☐ Yes ☐ No

If yes, please list _____

Is your child taking any medications now? ☐ Yes ☐ No

If yes, please list _____

_____

_____

Reason for medication(s) _____

_____

_____

_____

Medical Conditions

Does your child have or has your child ever had any of the following:

N Y		N Y		N Y	
☐☐	Cerebral Palsy	☐☐	Heart Ailments	☐☐	Thyroid Disorders
☐☐	Pregnant	☐☐	Excesive Bleeding from Cut or Extraction	☐☐	Ulcer or Colitis
☐☐	Learning Disability	☐☐	Anemia or Blood Problems	☐☐	Malignancies or Leukemia
☐☐	Psychiatric care/emotional problems	☐☐	Asthma or Other Respiratory Problems	☐☐	Chicken Pox
☐☐	Hyperactivity/ADHD	☐☐	Sinus Problems	☐☐	Mononucleosis
☐☐	Temper Tantrums	☐☐	Tonsillitis	☐☐	Hearing Problems
☐☐	Extreme Nervousness or Apprehension	☐☐	Tuberculosis	☐☐	Eye Disorders
☐☐	Epilepsy or Seizures	☐☐	Kidney Problems	☐☐	Physical Handicaps
☐☐	Rheumatic Fever	☐☐	Diabetes	☐☐	AIDS/HIV+
☐☐	Heart Murmur	☐☐	Liver Problems, Jaundice or Hepatitis	☐☐	Autism Spectrum Disorder

Describe any current medical condition not listed above _____

Social History

Interests _____

Favorite Toys _____

Sports Played _____

Pets _____

Special Experiences _____

_____

Please list any questions that you would like answered: _____

_____

_____

_____

Parent / Guardian Signature _____ Date: _____

Doctor Signature _____ Date: _____

Children's Dental Center of Monmouth
2 Apple Farm Road
Red Bank, New Jersey 07701

Welcome to our practice. At The Children's Dental Center of Monmouth we recognize that life is busy and that a parent or legal guardian cannot always be present. New Jersey regulations state that if a parent or legal guardian cannot be present at a dental appointment then a limited power of attorney may granted to make dental and medical decisions. We have included this form in our packet to give you the option of placing in your child's dental record. If you choose to fill it out we will keep it on file. If you decide in the future you may come to the office and sign it, or have it notarized brought with child a future appointment

Thank You

Children's Dental Center of Monmouth

I acknowledge that I have read and understand that minors must be accompanied by a parent or legal guardian, or power of attorney must be granted to another responsible adult in writing (either signed directly in front of office staff or through a notarized letter.

_____

Signature of Parent/Legal Guardian

INFORMED CONSENT FOR PEDIATRIC DENTISTRY

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child.

Please read this form carefully and ask about anything you do not understand.

EXAM

Every child is a unique individual. Thus, not every child will require the same treatment to obtain a comprehensive oral examination. Based upon your child's age, teeth present, and tooth position, the Doctor will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride.

TREATMENT

If your child should need any dental treatment after the dental examination has been completed, the Doctor will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

- It is our policy that all treatment options are explained to the parent(s), including treatment alternatives, advantages and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.
- Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection. On rare occasions complications may arise that require hospitalization.
- I agree to remain within the dental office facility where my child is being treated.

I have been advised of the benefits, risks, and possible side effects of proposed treatment, and possible consequences of not receiving treatment. Treatment alternatives, including no treatment, have been presented to me and all of my questions regarding my child's care have been answered satisfactorily. With my signature, I authorize Children's Dental Center of Monmouth/Lakewood Pediatric Dental Associates to perform a dental exam upon my child and I acknowledge that I have reviewed the possible risks and complications associated with dental treatment.

Patient Name _____

Parent/Guardian Signature _____ Date _____

CHILDRENS DENTAL CENTER OF MONMOUTH, PA
2 Apple Farm Road, Red Bank, NJ 07701
Phone: (732)671-1266 Fax: (732)671-2166

X-RAYS & CLEANING INFORMATION

Date of Last Cleaning _____

Place of Last Cleaning _____

Date of Last X-Rays _____

If cleaning and x-rays were done within the last six months most insurance companies will not cover the expense.

Therefore, if a cleaning is done in this office within six months of a previous cleaning & set of x-rays it will be the monetary responsibility of the parent, guardian or custodian of the child.

I, _____ **will take full responsibility for payment of x-rays or cleaning if same was done within six months of the date.**

I,_____ **will take full responsibility for any and all procedures at Children's Dental Center of Monmouth due to frequency of the same procedure; i.e. sealants, cleaning, fluoride panoramic x-rays, full mouth x-rays, replacement of space maintainer not covered by insurance.**

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Patient Acknowledgement Form

I, _____, acknowledge that I have received and reviewed the office Privacy Policy Notice for Children's Dental Center of Monmouth, P.A.

Parent/GuardianSignature:_____Date:_____

In case you do not agree to sign this form, our office must indicate why you declined to do so. This office will not refuse treatment to anyone based solely on the patient's refusal to sign the acknowledgement form.

Reason for patient's refusal: _____
_____
_____

Privacy Director's Signature:_____Date:_____

PRIVACY POLICY NOTICE

Children's Dental Center of Monmouth,P.A.

2 Apple Farm Rd Red Bank NJ 07701

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES

Our office must provide you, the patient, a description and at least one example of the type of uses and disclosures that our office is permitted to make for the purpose of treatment, payment and health-care operations (all uses and disclosures by the way, that are permitted by the law without authorization by the patient.)

Treatment – Our office will use and disclose your protected health information (PHI) for purpose of treatment, meaning the provision, coordination and management of your health care and related services. For instance, we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and a specialist if required for your care.

Payment – Our office may use and disclose the minimum necessary amount of your PHI for health-care operations, such as business planning and development that involves conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development and improvement of methods of payment or coverage policies.

This section of our policy also must describe other purposes for which our office is permitted or required to use or disclose your PHI without your written authorization. No examples of each of the following instances is required in this notice.

Required by law – Our office may use and disclose your PHI only to the extent that such use is required by law.

Public health activities – Our office may use and disclose the minimum necessary amount of your PHI to appropriate public health authorities for reasons such as, but mot limited to, preventing or controlling disease, injury or child abuse or neglect.

Reporting abuse, neglect or domestic violence – Our office may use and disclose the minimum necessary amount of your PHI to the extent necessary to inform the appropriate government authority if we reasonably believe you to be a victim of abuse, neglect or domestic violence.

Health oversight activities – Our office may use and disclose the minimum necessary amount of your PHI to a health oversight agency for oversight activities authorized by law, such as for, but not limited to, audits.

Judicial and administrative proceedings - Our office may use and disclose the minimum necessary amount of your PHI in the course of any judicial or administrative proceeding if required by law to do so.

Law enforcement agencies - Our office may use and disclose the minimum necessary amount of your PHI to a law enforcement agency is required by law to do so.

Deceased patients - Our office may use and disclose the minimum necessary amount of your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining cause of death or another matter authorized by law, or to funeral directors to carry out their duties with respect to the deceased individual.

Research purposes – Our office may use and disclose the minimum necessary amount of your PHI for research purposes without your written authorization only if we have obtained one of the following documented institutional review board or privacy board approval, either written or verbal representations that the information is to be used only to prepare a research protocol, either written or verbal representations that the information being sought is solely for research on the PHI of decedents, or a limited data use agreement.

Specialized government functions – If you are a member of the Armed Forces, our office will use and disclose the minimum necessary amount of your PHI for military and veterans activities. Our office also will use and disclose the minimum amount of your PHI for national security and intelligence activities for protective services for the U.S. President and others. Our office also will use and disclose the minimum necessary amount of your PHI to a correctional institution or law enforcement agency if you are an inmate and that agency or institution indicates the information is necessary

Safety – Our office may use and disclose the minimum necessary amount of your PHI if we believe doing so is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and other special circumstances.

Workers' compensation proceedings – Our office may use and disclose the minimum necessary amount of your PHI as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs.

Patient directory – Except when an objection is expressed by you, our office may use and disclose the minimum amount of your PHI to maintain a directory of patients in the office. Said information includes your name, your location in the office, your condition described in general terms. We will inform you in advance of such need and give you an opportunity to object, except in cases of emergencies when we must exercise professional judgment to determine whether use and disclosure of this information is in you best interest.

Friend, family and personal representatives - Our office may use and disclose the minimum necessary amount of your PHI that is directly relevant to the involvement of a family member, other relative, a close personal friend or someone else identified by you. Involvement could be in relation to care or payment for services. Our office also will use and disclose the minimum necessary amount of your PHI regarding your location, general condition or death to a family member, a personal representative of yours or another person responsible for your care. Such uses and disclosures will be made only with your permission if you are present, unless you are incapacitated or there is an emergency circumstance where our office must exercise professional judgment.

Federal Investigation – Our office may use and disclose the minimum necessary amount of your PHI for an investigation by the U.S. Department of Health and Human Services Secretary to determine if our office is in compliance with the HIPAA privacy regulation that requires us to protect your individually identifiable health information.