Dear Parents,

Welcome to our practice! We are happy that you have chosen us for your children's dental care. We will do everything possible to make your visits pleasant. We take great pride in our ability to provide the finest pediatric, orthodontic and adolescent dental services.

Modern, progressive pediatric and orthodontic dental practices, such as ours, believe in preventive dental care. Our philosophy of prevention, combined with conservative treatment, will help to keep dental costs down and treatment to a minimum. Along with your cooperation, we can keep your children's teeth healthy and attractive.

Their first visit with us will be approximately 30 minutes. **If indicated**, we may need to take a series of radiographs (X-rays). The number and type of X-rays taken is determined by the age, need and cooperation of the child. These X-rays provide us with information about possible cavities, growth and development of all the baby and permanent teeth and evaluate other possible dental problems.

We would like to make their visit with us as pleasant and positive as possible. If this is their first visit, you can help at home by telling them that they are going to visit the dentist (the doctor that takes care of their teeth) to have their teeth checked. You might also mention that special pictures may be taken of their teeth. Please avoid using terminology that might make them anxious (like drill, pull, needle, etc.). Please mention to them that our office has a great play area, video games and a special fish tank in our reception area.

Please **COMPLETE AND SIGN** all of the forms and bring them with you to your first visit. If you have dental insurance, please be sure to provide us with **all** of the information indicated in the insurance section of the form. **All of this information is NECESSARY to process your insurance.**

We suggest that they have nothing to eat or drink two hours prior to this visit. If you feel that they must eat something, please give them small amounts of juice and dry cereal or toast - **Please do not give them any dairy products, if possible!**

We are looking forward to meeting you and your children. If you have any questions or concerns, please do not hesitate to call us.

Irvin B. Sherman DDS MScD
Diplomate – American Board of Pediatric Dentistry
Fellow – American Academy of Pediatric Dentistry

Frederic Paperth DMD
Fellow – American Academy of Pediatric Dentistry

Jocelyn Jeffries-Bruno DDS
Britni L. Kearns DMD
Neha M. Jiwani DDS

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NEW PATIENT REGISTRATION

Today's Date ______________________ Chart # ________________

CHILD'S INFORMATION

Last Name ______________________________ First Name ______________________ Nickname ________________________
Age _____________ Birthdate ____________________ Sex: Male / Female Home Phone # ____________________________
Pharmacy Name & Phone #: ____

PARENT INFORMATION

Mother's Full Name ____ SS# __________________ DOB ______________
Home Address ____ City _________________________ Zip ______________
Employer ____ Employer's Address ___________________________________
Cell # _______________________ Work #_____________________ Email Address ____________________________________
Father's Full Name ______________________________________ SS# _________________ DOB _______________
Home Address ____ City _________________________ Zip ______________
Employer ____ Employer's Address ___________________________________
Cell # _______________________ Work #_____________________ Email Address ____________________________________
Marital Status: Married _________ Single __ Separated ________ Divorced ____ Widowed _______
Who does the child live with? Both Parents _________ Mother _________ Father _________ Other ____________________
Yes, please send me email and/or text message reminders about my child's appointment:
Email address ____ Phone to text _________________________________
Names and ages of other children in your family:
____________________________ __________________________ ________________________________
____________________________ __________________________ ________________________________
Emergency Contact (other than parents): Name ____
Relationship to Patient _______________________________ Phone # ___________________________
Address ____ City _______________________________ Zip ______________
How did you hear about Shore Children's Dental Care?
______ Insurance Company ______ School Talk ______ Commercial ______ Family or General Dentist
______ Pediatrician ______ Facebook ______ Google _______ Other _______________________
______ Friend / Family (please provide name) ______________________________

MEDICAL INFORMATION

1. Your child's health is: Excellent _________ Fair ________ Poor ______
2. Name of child's Pediatrician ____ Phone # ____________________________
   Address ____ City ______________________________ Zip ______________
3. Is your child taking any medication at present? Yes ________ No _________
   If yes, what are the medications? ____
   ____
4. Has your child ever had an unfavorable reaction to a local (Novocain) or general (gas) anesthetic? Yes _____ No _______
   If yes, please describe the situation ____
5. HAS YOUR CHILD EVER BEEN ALLERGIC TO ANY MEDICINE, FOOD, OR SUBSTANCE? If so, please list _________________
   ____
6. Has your child had any bleeding problems? ____
7. Has your child had any history of the following:

____ Anemia ____ Chicken Pox ____ Down's Syndrome ____ Heart ____ Muscular Dystrophy
____ Asthma ____ Chronic Sinus ____ Ear Infections ____ Kidney ____ Rheumatic Fever
____ Autism ____ Colds ____ Epilepsy ____ Liver ____ Skin Disorder
____ Bladder ____ Convulsions ____ Fainting ____ Measles ____ Thyroid
____ Cancer ____ Diabetes ____ Glands ____ Mononucleosis ____ Tuberculosis
____ Cerebral Palsy ____ Digestion ____ Hearing ____ Mumps ____ Other _________________

8. Please comment on any of the above checked items if you feel it is significant _____________________________________
   ____
9. Has your child ever had any hearing, sight, speech, coordination, or special schooling problems? __________ If so, please describe
   ____
   ____
10. Was the term of pregnancy and birth normal with respect to your child? __________ If not, please state any complications or problems including prematurity, low birth weight, or medications taken ____
11. Can you offer any other information about your child or family's health, which may help us in providing them with appropriate dental care? _________
    ____

DENTAL INFORMATION

1. Family Dentist ______________________ Child's Previous Dentist ______________________
2. What is the reason for bringing your child to this office? ______________________
3. Is this your child's first visit to a dentist? _____ If not, when was the last visit? ______________________ Was any treatment done? ______________________
4. Date of last dental x-rays ______________________ By whom? ______________________
5. Has there been a problem associated with previous dental care? ______________________
6. Has your child ever received: a) Home care instruction? ____ b) Diet analysis _______ c) Topical fluoride treatment _____________
   d) Fluoride supplements (drops, vitamins, etc.)? __________ If yes, what is the name? ______________________
7. Does your child have a history of:
   - ______ Thumb sucking
   - ______ Bed Wetting
   - ______ Mouth Breather
   - ______ Tongue Thrusting
   - ______ Object or Nail Biting
   - _______ Speech Problem
   - ______ Other ______________________
8. Has any member of your family had any unusual dental problem? ______________________
9. Has there ever been an injury to your child's teeth or mouth? ______________________
10. At what age did your child's teeth first appear? ______________________
11. At what age was your child taken off the bottle? ______________________
12. At what age did your child walk? ______________________ Talk? ______________________
13. How often does your child brush his/her teeth? __________ Supervised? ______________
14. Are you concerned about any special dental problems now? ______________________
15. Is your child experiencing any dental pain or discomfort now? ______________________
16. What do you think of the condition of your child's teeth? ______________________

PERSONAL INFORMATION

1. Name of School ______________________ Grade ______________________
2. Child's interests, hobbies, talents, etc. ______________________
3. Is your child in a special education program? Yes ____ No __________
4. Please describe your child's temperament:
   - ______ Shy
   - ______ Fearful
   - ______ Outgoing
   - _____ Manipulative
   - ______ Easy Going
   - _ Calm
   - ______ Requires special understanding
5. Can you offer any other information about your child's emotional and developmental status, which could help us in giving your child the best dental experience and care? ______________________
6. Please list any questions you would like to have answered.
   1. ______________________
   2. ______________________
   3. ______________________
   4. ______________________

==

CONSENT FOR TREATMENT

I, ______________________ give permission for this office to render any necessary dental treatment to my
Name of Parent or Guardian

Child ______________________

Signed ______________________ Date ______________________
Signature of Parent or Guardian

Patient's Name ____ Date ______________________________

INSURANCE VERIFICATION

New Jersey law requires us to disclose full insurance information on all claims submitted; therefore, our office requires the following information:

Primary: Insured's Name ______________________________________ Birth Date ______________________

Address ____ SS # ___________________________

Employer Name ____

Employer Address ____

Insurance Company - Name ____

Address ____

Tel No. ____

ID # ____________________________ Group/Plan # ___________________

Secondary: Insured's Name ______________________________________ Birth Date ______________________

Address ____ SS # ___________________________

Employer Name ____

Employer Address ____

Insurance Company - Name ____

Address ____

Tel No. ____

ID # ____________________________ Group/Plan # ___________________

If any dependent child is over the age of eighteen, please supply the following:

Name of child ____

Name of F/T school attending ______________________________________

Please be advised that our office only processes your primary insurance claims.
Once your primary insurance has paid us, you assume full financial responsibility for any balance remaining.
It is also your responsibility to process any claims needed for your secondary insurance.
The above secondary insurance information is for disclosure purposes only.
Thank you for your cooperation.

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NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

Notice of Privacy Practices can be found on our website

I, ______________________________, have read and understand this office's Notice of
(print full name)

Privacy Practices.

____
Signature

____
Date

For 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 us from obtaining acknowledgement
- ☒ Other (Please Specify)

____

____

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FINANCIAL POLICY

Payment is due in full at the time dental treatment is provided. We accept cash, personal check, debit and credit card payments. We can also assist you in obtaining third party financing through CareCredit, which offers convenient monthly payment options, no up-front costs, no prepayment penalties and no annual fees.

Insurance

Our office is committed to helping you maximize your insurance policy and will gladly accept assignment of benefits. Because insurance policies vary greatly, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. As our fees may exceed that which your insurance company covers for various services, your estimated patient portion must be paid at the time of service. Should your payment exceed the estimated patient portion, you will promptly be refunded the difference. Our office is not a contracted or "in-network" provider for **all** insurance companies, and as such, any fees not covered by your insurance company are solely your responsibility. As a service to our patients, we will bill insurance companies for services.

In an effort to reduce the amount of billing errors, paper statements, and past-due collections accounts, we require that you keep a debit or credit card authorization on file with our office. This authorized method of payment will be used to clear any potential balances that may occur after we receive payment from your insurance company. In the event that it becomes necessary to use this authorized method of payment, you will receive a courtesy phone call to the primary phone number provided before any charges are assessed. If no response is received after 48 hours, the charges will automatically be assessed and you will receive a receipt and a copy of your patient account statement via mail.

If your account balance is 120+ past due, it will be turned over to a collections agency. Please contact our office to discuss additional payment options should the need arise.

I have read, understood, and had all questions answered about the financial policies in effect at Shore Children's Dental Care.

Print Name: ________________________________

Signed: ____________________________________ Date: ______________________

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Credit Card Authorization

I authorize Shore Children's Dental Care to keep my signature of file and to charge the following credit card should a balance remain on my account.

- I understand that the estimated patient portion of my office visit will be collected at the time of service.
- Once insurance has been processed, if a balance remains on my account, I will receive a statement in the mail that I must pay within 30 days. If this amount is not paid within that time, I understand that I will receive a courtesy call that the amount will go on my card.
- If this authorization applies to a payment plan option previously agreed upon with a staff member of SCDC, I understand that my card will be charged $ _______________ on the _____ day of every month until my balance is paid in full. Initials ______________
- In the event of an overpayment on the following credit card, I will receive a courtesy call and be given options for reimbursement.

Patient Name(s): ____

Phone (H): ___________________ (W): __________________ (C): __________________

Card Type: VISA _______ MASTERCARD _______ DISCOVER _____ AMEX _________

Card # _______________________________________ CVV Code ______ Exp Date _____________

Name As It Appears On Card: ____

Cardholder Signature: ______________________________________ Date: ______________________

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