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. _____

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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

SHORE
CHILDREN'S DENTAL CARE
Avon by the Sea • Manasquan

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.

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
Diplomate – American Board of Pediatric Dentistry

Britni L. Kearns DMD

Jason V. Tesoriero DDS

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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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