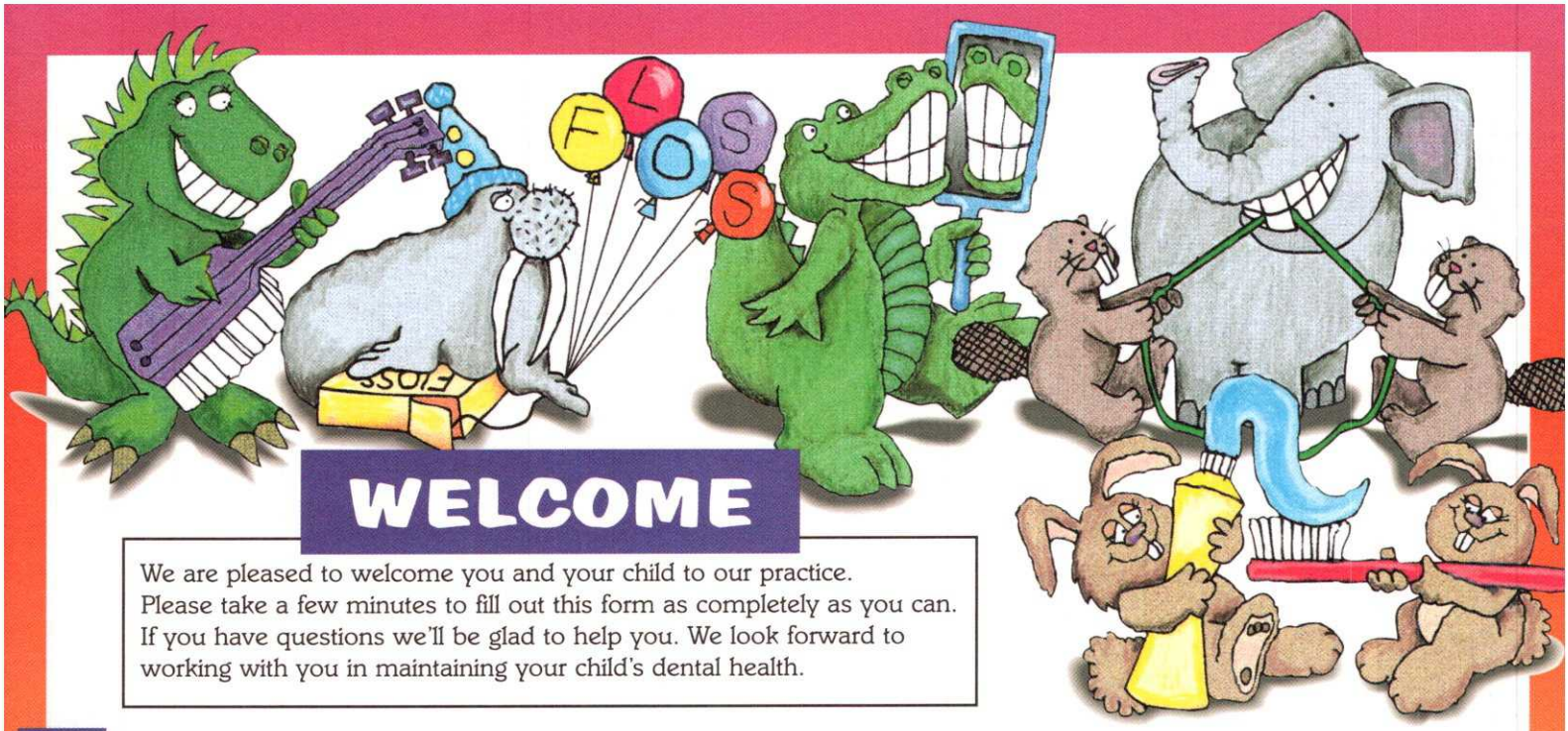


WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

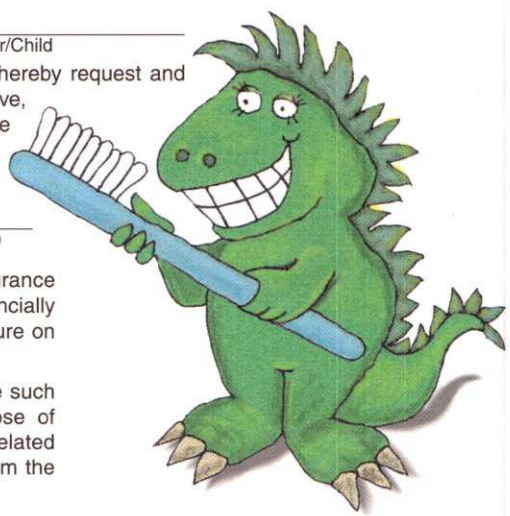
AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.



Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

THE ADVANCED DENTAL CENTER of CEDAR KNOLLS
GEORGE J SCHMIDT DMD BRANDON K SCHMIDT DMD
197 RIDGEDALE AVENUE SUITE 245
CEDAR KNOLLS NJ 07927
973-889-1900

UNDERSTANDING YOUR FINANCIAL CHOICES

When you make any decision regarding dental treatment it is important that you understand the financial decision you are making at the same time. We are committed to fully informing every patient every time of their financial responsibility prior to treatment.

You are responsible for the cost of treatment provided in our office.

- To support your financial responsibility we will always tell you in advance of providing any dental service what your expected costs will be.

If you have a dental plan, we will work with you to understand your anticipated benefits as they apply to your treatment choices.

- We will help you determine how your plan reimbursement will affect your payment to our office for dental services, considering reimbursement method, levels of coverage, co-payments, deductibles, limits, and services not covered.

Your payment to our office is due on the day of service.

- For treatment that is completed in a single appointment, the full amount of your payment is due on the day of the appointment. _____ (Initial)
- For treatment that requires multiple appointments we will inform you of the payment amount that is due each appointment. _____ (Initial)

Payments can be made by cash, check, debit card, Visa, Mastercard, Discover, or American Express.

- When extensive dental treatment is planned our office can facilitate payment arrangements with a third party dental finance company.

Your dental treatment is important to your health. We always welcome questions you have about dental care and the costs of care. We are committed to you and to the treatment and payment option that is right for you.

In order for us to accept Assignment of Benefits from your insurance and allow you to carry a balance on your account, we will require your Social Security number. If you do not wish to provide your social security number, you may pay for your appointments in full and we will provide you with any necessary reimbursement forms. _____ (Initial)

NAME_____DATE_____

THE ADVANCED DENTAL CENTER
-CEDAR KNOLLS-
GEORGE J SCHMIDT DMD BRANDON K SCHMIDT DMD
197 RIDGEDALE AVE SUITE 245
CEDAR KNOLLS NJ 07927
973-889-1900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDEGEMENT****

I, _____ (child's name) HAVE REVIEWED A COPY

OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____

(PLEASE PRINT NAME) → parent /guardian's name

_____

(SIGNATURE)

_____

DATE

_____

OFFICE USE ONLY

_____

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

[ ] INDIVIDUAL REFUSED TO SIGN

[ ] COMMUNICATIONS BARRIER PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

[ ] AN EMERGENCY SITUATION PROHIBITED US FROM OBTAINING ACKNOWLEDGEMENT