PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Childs Information

Name _____
Last First MI (Preferred)

Birthdate _____ SS# _____ Gender: [ ] M [ ] F

Work Phone _____ Wireless Phone _____ Wireless Carrier _____

Parent's Information Parent's Name _____

Email _____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Comments:

Authorization - Non - Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present a photo identification at each time of service.
This authorization gives the person listed below permission to bring your child(ren) to appointments and speak to the doctor regarding protected health information. Furthermore, this authorization allows the person(s) listed below the authority to give authorization and consent for all general dental and health decisions with no restrictions

I also understand I am responsible for any expenses incurred in my absence.

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

(IF ONLY PARENTS CAN BRING CHILD IN, PLEASE INDICATE 'NONE')

Name of Person (allowed to bring child) : _____

Relationship: _____

Name of Person (allowed to bring child) : _____

Relationship: _____

Signature(Parent/Guardian):

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature and not enough time to seek out my specific consent. This consent will remain in effect until, I notify Lawrenceville Pediatric Dentistry in writing.
For any questions regarding this consent please contact me at the below information. I will try to stay available during my child(ren)'s appointment time to answer any questions that may arise.

Parent/Legal Guardian Name:_____

Check Preferred Phone#:_____

Address: _____

Financial Agreement

Last Name: First Name: Birthdate:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes
☐ No

GENERAL CONSENT FOR TREATMENT

Parents: Prevailing medical/dental practice law requires that we ask you to read the following and sign at the bottom of the page. We apologize in advance for the impersonal nature of this form.

1. I am the parent or guardian of _____ and have legal authority to give consent for medical/dental treatment for him/her.
2. I give my consent to Dr. Shikha Sharma to render dental and/or any emergency medical procedures deemed necessary or advisable.
3. I give my consent to use local anesthetics, nitrous oxide (laughing gas), radiographs (Xrays), fluoride, fillings, extractions, stainless steel (silver) crowns, nerve treatment, photographs as needed for diagnosis, patient records and insurance requirements or documentation.
4. The aspects of dental treatment have been previously explained to me to my satisfaction: the procedures, the benefits and disadvantages of treatment, any alternatives, possible side effects and complications, as well as the prognosis if no treatment is provided.
5. I do not give my consent for the following procedures.

_____

_____

_____

6. I understand that in the course of treatment my child may become uncooperative and restraint may be necessary (e.g. hand holding) to safely complete treatment. I also understand that I will be informed during and after treatment if this is necessary.

7. I understand that, although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there is no guarantee expressed or implied either to the result of the treatment or as to the cure.
8. I have been given an opportunity to ask any questions I might have.
9. This consent will be in force indefinitely until rescinded by me.
10. I have read, and I understand this consent form.

Patient Name:

Relationship to Patient: _____

Signature of Parent/Guardian Below:

Notice of Privacy Policies

Last Name: First Name: Birthdate:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Photography Form

Dear Parent/Guardian,
As the parent or guardian of the child/children at LAWRENCEVILLE PEDIATRIC DENTISTRY, I agree to the following:
I understand that my child(ren) whose name(s) are listed below may be photographed at LAWRENCEVILLE PEDIATRIC DENTISTRY during normal hours and treatments. I understand that the photographs may be used in promoting dental services, either in print or on the Internet.

Parent / Guardian Name: Relation to Child:

Child Name:

Address:

☐ I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting Lawrenceville Pediatric Dentistry. I understand that is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.

Initials: _____

Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Heart Murmur	☐	☐	Sinus Trouble
☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Rheumatic Fever

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Do you have any other allergies not listed above? Please specify _____

_____

Date:

OFFICE POLICIES REGARDING

APPOINTMENTS:

I understand that:

*I must present my insurance card at every appointment.
*Payment is expected at the end of each appointment.
*If I am more than 10 minutes late for my scheduled appointment, the appointment may need to be rescheduled.
*A legal guardian must be present and remain in the office while their child receives treatment.
*Changes or cancellations to appointments must be made 24 hours prior to the scheduled appointment time.

DISMISSAL FROM OUR OFFICE:

Unfortunately, we must dismiss patients who:

*Miss 2 scheduled appointments in one year. A rescheduled appointment due to tardiness is considered to be a missed appointment.
*Fail to schedule and/or keep treatment appointments within 30 days after decay has been detected and treatment recommended.
*Fail to adhere to the financial policies outlined in our Office Policies.

If you have any questions regarding these policies, please do not hesitate to ask the front desk receptionists.
I understand and agree with the above stated policies regarding appointments and dismissal procedures. I have also been given a copy of the "Notice of Privacy Practices" brochure.

Parent / Guardian Signature: