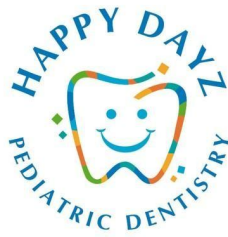


Date: _____



505 Stillwells Corner Road
Suite C1, Freehold, NJ 07728
Phone (732) 780-3300
info@happydayzpd.com

NEW PATIENT INFORMATION

Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
DOB: _____ Age: _____ Gender: _____	DOB: _____ Age: _____ Gender: _____
Primary Language: _____	Primary Language: _____

IN THE EVENT OF AN EMERGENCY, WHOM SHALL WE CONTACT?

Name: _____ Relationship: _____ Phone Number: _____
How were you referred to our office? Facebook ___ Yelp ___ Sign ___ Insurance ___ Google ___
Another doctor (specify): _____ Another patient (specify) _____

DENTAL INSURANCE INFORMATION

Name of Subscriber: _____ DOB of Subscriber: _____
Insurance Type: _____ Subscriber ID #: _____
Group Number: _____ Company Name: _____

PARENT/GUARDIAN INFORMATION

Mother ___ Father ___ Grandparent ___ Legal Guardian ___ Other (specify) _____
Name: _____ DOB: _____ SSN: _____ Employer: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Preferred method of contact: Phone call ___ Text ___ Email ___
Mother ___ Father ___ Grandparent ___ Legal Guardian ___ Other (specify) _____
Name: _____ DOB: _____ SSN: _____ Employer: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Preferred method of contact: Phone call ___ Text ___ Email ___

Date: _____ Patient Name : _____ D.O.B: _____

Parent Dental History

DR. SIGNATURE _____

Reason for this visit: Check-up/Cleaning Cavities Mouth Injury Tooth Pain Oral Habits Other (specify): _____

Last dental visit: _____ Reason: _____ Dentist Name: _____

Reason for leaving: _____

Patient Medical History

Primary Care Physician/Pediatrician Name: _____

Preferred Pharmacy: _____ Address: _____

Has your child ever or does he/she currently:

Take Medications YES NO EXPLAIN _____

Been Hospitalized YES NO EXPLAIN _____

Had Surgery YES NO EXPLAIN _____

Have Allergies YES NO EXPLAIN: _____

Is your child receiving any therapy from any other providers? (i.e., PT, OT, ABA, EI, etc.)

YES NO EXPLAIN: _____

Has your child ever or does he/she currently have a history of:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> CANCER | <input type="checkbox"/> GASTRIC REFLUX | <input type="checkbox"/> PREGNANCY |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PREMATURE BIRTH |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> PROBLEMS WITH ANESTHESIA |
| <input type="checkbox"/> AUTISM SPECTRUM | <input type="checkbox"/> DEVELOPMENTAL DELAY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PROLONGED BLEEDING |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEPATITIS/LIVER DISEASE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> DOWN SYNDROME | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> SEASONAL ALLERGIES |
| <input type="checkbox"/> BIRTH DEFECT | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> BLOOD DISORDER | <input type="checkbox"/> EAR/EYE/NOSE TROUBLE | <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> MTHFR GENE MUTATION | OTHERS: _____ | | |

Comments: _____

ACKNOWLEDGEMENT OF PATIENT INFORMATION / AUTHORIZATION FOR INITIAL EVALUATION

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child for an initial evaluation. Any other dental services required will be explained and authorized by me after the initial visit.

DELEGATION OF POWER BY PARENT OR GUARDIAN

I give my consent to allow the person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke this consent at any time by providing written notice.

Persons who have consent in my absence are:

I confirm that I have read and fully understand the above.

Parent/Relative/Guardian: _____

Signature

Print Name

Relationship (If signed by person other than parent): _____

Interpreter (If Required) : _____

Signature

Print Name

*Signature of the parent must be obtained unless the patient is an emancipated minor under the age of 18 or is otherwise incompetent to sign.

Date: _____

Patient Name: _____ D.O.B: _____

NOTICE OF OFFICE PRACTICES

Our practice is fully committed to providing you with excellent dental experience and the best possible care we can render. We are open and available to discuss our professional fees with you at any time. Your clear understanding and acceptance of our financial policies is important to us and important to establishing a sound professional relationship.

VERIFYING INSURANCE

As a courtesy to you, we will verify your insurance benefits prior to your new patient appointment, as well as anytime you notify us of an insurance change thereafter. The insurance companies do not guarantee payment based on the information you tell us; therefore you are responsible for knowing of any required waiting periods. Any amounts on procedures not covered, are your financial responsibility.

PAYMENT

Payment is due at the time the service is rendered. The adult accompanying the child is responsible for payment at the time of the appointment. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount in full as well. During treatment it may be necessary to change or add procedures due to conditions found while working on your teeth. Payment for services rendered will be due at the time of service. The insurance portion of the treatment plan is an estimate and not a guarantee of coverage. Your estimated portion will be due at the time of service. If your insurance carrier pays less than the anticipated amount, you will be responsible for the unpaid balance. I understand that I am responsible for any unpaid balance for the procedures that are performed. I authorize the dentist or qualified assignee to perform the work described above and to make any necessary changes or additions thereto.

BALANCES

If your account balance exceeds 60 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collection agency. If this happens, a collection fee will be added to your balance. The collections agency will report any unpaid balances to the credit agencies.

CANCELLATIONS/FAILED APPOINTMENTS

There is a \$50 missed appointment fee. If cancelling within 24 hours of appointment. For appointments on Mondays or after a holiday, 24 hours is from last business day, not including Saturdays and Sundays. The fee will be posted to your account and additional appointments will not be made until the balance is settled. Excessive tardiness, cancellations without adequate notice and failed appointments may result in termination of doctor-patient relationship.

INSURANCE

I certify that my child is covered by insurance and benefits are assigned to the office. I understand that I am financially responsible for all charges not covered by dental insurance. I hereby authorize the office to release all necessary information on to secure payment of benefits. I authorize the use of this signature on all insurance submissions. We bill your insurance as a courtesy to you. It is **YOUR** responsibility to be familiar with your plan coverage, limitations, and copays, etc. We advise that you follow up with your insurance carrier on any claims unpaid after 60 days from date of service. **CLAIMS THAT ARE NOT PAID FOLLOWING 90 DAYS FROM DATE OF SERVICE** will become patient responsibility for payment **AT TIME OF VISIT.**

CREDIT CARD AUTHORIZATION

It is our office policy to obtain your credit card information and authorization to process a payment should your dental insurance not honor the claim submitted, you have remaining out of pocket expense, or if you breach the office's cancellation policy. In providing credit card information below, you authorize payment by credit card services in the absence of coverage by your dental insurance (including but not limited to, copayments, deductibles, and/or non-covered services), missed appointment fees, and/or bounced checks and associated bank fees. A phone call to the card holder listed below will be made prior to making a charge.

Name on Credit Card: _____ Billing Zip Code: _____

Credit Card Number: _____ CVV/CID _____ Exp Date: _____

Signature: _____

I confirm that I have read and fully understand the above.

Parent/Relative/Guardian: Signature _____ Print Name _____

Relationship (If signed by person other than patient): _____

Interpreter (If Required) : signature _____ Print Name _____

*Signature of the parent must be obtained unless the patient is an emancipated minor under the age of 18 or is otherwise incompetent to sign.

Date: _____

Patient Name: _____ D.O.B: _____

CONSENT FOR OUTPATIENT TREATMENT ASSIGNMENT OF BENEFITS

AUTHORIZATION

I hereby authorize the dentist and other health care professionals to provide such health care and to administer such treatment as deemed necessary or advisable to me or the named patient each time I or the named patient present to the office. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

MEDICARE/MEDICAID PATIENTS

I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment below.

GUARANTEE OF ACCOUNT

For and in consideration of service rendered to (patient name) by the office, I hereby agree to pay the full bill for all charges which are not covered by the insurance, or any balance due which is not covered by insurance or excluded by a co-insurance clause.

RELEASE OF INFORMATION

I permit the office to disclose all or part of the above patient's medical record to any person, corporation, or agency when required for the collection of benefits or payment of hospital charges.

ASSIGNMENT OF BENEFITS

I assign to the office all benefits from any corporation, agencies, and person for these services. Additionally, I authorize payments of these benefits directly to the office.

HIPPA ACKNOWLEDGEMENT

1. I authorize the practice to release staff, hospitals, health service plans, insurance companies, self-insurers or their representatives, specialty dentist involved in my child's care, any speech agencies, occupational / feeding therapists, any and all information records, and other diagnostic material about my child's medical history, services rendered, or recommended treatment.

2. I authorize sharing my child's protected health information with individuals who may be involved in my child's care and I understand I am responsible to notify the practice of any changes.

I confirm that I have read and fully understand the above.

Parent/Relative/Guardian: _____
Signature _____ Print Name _____

Relationship (If signed by person other than patient): _____

Interpreter (If Required) : _____
Signature _____ Print Name _____

*Signature of the parent must be obtained unless the patient is an emancipated minor under the age of 18 or is otherwise incompetent to sign.