Your Child's Dental History and Habits

Your Child's Name _____ **Nickname** _____ **Date** _____

Welcome! So that we may provide your child with the best possible care, please complete both sides of this dental/ medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions

What is the reason for your visit today? _____

_____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? ..... ❑ Yes ❑ No

Is your child's water fluoridated? ..... ❑ Yes ❑ No Does your child take fluoride supplements? ..... ❑ Yes ❑ No

Does your child have any dental problems now? ..... ❑ Yes ❑ No If yes, please describe _____

_____

How do you think your child will do? ..... ❑ Good ❑ Fair ❑ Poor

Has your child had difficulty with previous dental visits? ..... ❑ Yes ❑ No If yes, please describe _____

Has your child complained about dental problems? ..... ❑ Yes ❑ No If yes, please describe _____

Has your child ever worn orthodontic appliances? ..... ❑ Yes ❑ No If yes, please describe _____

Are any of your child's teeth sensitive to:

Hot or cold? ..... ❑ Yes ❑ No Sweets? ..... ❑ Yes ❑ No Biting or Chewing? ..... ❑ Yes ❑ No

Does your child engage in:

Sucking thumb or fingers? ..... ❑ Yes ❑ No

Biting or sucking lips or cheeks? ..... ❑ Yes ❑ No

Grinding teeth? ..... ❑ Yes ❑ No

Mouth breathing? ..... ❑ Yes ❑ No

Chewing or biting fingernails? ..... ❑ Yes ❑ No

Chewing hard objects (e.g., pencils)? ..... ❑ Yes ❑ No

Clenching jaw? ..... ❑ Yes ❑ No

Nursing bottle or pacifier habits? ..... ❑ Yes ❑ No

Do your child's gums bleed or hurt? ..... ❑ Yes ❑ No

Does your child have any pain or tenderness in the jaw joint, ear, side of face? ..... ❑ Yes ❑ No

Do you have any special concerns about your child's dental health? ❑ Yes ❑ No If yes, please describe _____

_____

_____

Your Child's Medical History

Your Child's Name _____ **Nickname** _____ **Date** _____

Birth Date _____ **Patient Acct. No.** _____ **Medical Alert** _____

Your Child's Physician: Name _____ **Telephone** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Is your child under the care of a physician? ..... ❑ Yes ❑ No

If yes, please describe _____

Is your child taking any medications? (prescription or over-the-counter) ..... ❑ Yes ❑ No

If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment? ..... ❑ Yes ❑ No

Does your child have any allergic (or adverse) reaction to any medication or other substance? ..... ❑ Yes ❑ No

If yes, please list _____

Are your child's immunizations current? ..... ❑ Yes ❑ No

List Any Hospitalizations, Surgeries, Serious Illnesses **When?**

_____ _____

_____ _____

_____ _____

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

AIDS/HIV positive ..... ❑ Yes ❑ No	Congenital heart disease . ❑ Yes ❑ No	Lung problem ..... ❑ Yes ❑ No
Allergies or Hives ..... ❑ Yes ❑ No	Diabetes ..... ❑ Yes ❑ No	Measles/Mumps ..... ❑ Yes ❑ No
Anemia ..... ❑ Yes ❑ No	Epilepsy ..... ❑ Yes ❑ No	Mononucleosis ..... ❑ Yes ❑ No
Asthma ..... ❑ Yes ❑ No	Handicaps/Disabilities .... ❑ Yes ❑ No	Nervous disorders ..... ❑ Yes ❑ No
Behavioral/Learning problem ..... ❑ Yes ❑ No	Hay fever ..... ❑ Yes ❑ No	Psychiatric/Psychological ... ❑ Yes ❑ No
Bleeding disorder ..... ❑ Yes ❑ No	Hearing problem ..... ❑ Yes ❑ No	Rheumatic/Scarlet fever ..... ❑ Yes ❑ No
Brain Injury ..... ❑ Yes ❑ No	Heart condition ..... ❑ Yes ❑ No	Sickle cell anemia ..... ❑ Yes ❑ No
Cancer ..... ❑ Yes ❑ No	Hepatitis A B C (circle) .. ❑ Yes ❑ No	Stomach problem ..... ❑ Yes ❑ No
Cerebral palsy ..... ❑ Yes ❑ No	Kidney/Liver problem ..... ❑ Yes ❑ No	Tuberculosis ..... ❑ Yes ❑ No
Chicken pox ..... ❑ Yes ❑ No	Latex sensitivity ..... ❑ Yes ❑ No	

Other? ..... ❑ Yes ❑ No Please specify _____

_____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian _____ **Date** _____

Dentist's Review

Dentist's Signature _____ Date _____

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Jay M. Epstein, DMD, P.C.
295 Western Avenue
Lynn, MA 01904
781-598-2100

FINANCIAL POLICY

We offer high quality dental care to all of our patients, regardless of financial status or insurance coverage. We do, however, have a financial policy that each patient must read, understand and agree to.

Non-Insurance

Payment at the time of treatment is expected to keep our billing costs down; this also enables us to continue charging competitive fees to our patients. For patients receiving extensive treatment, it is our pleasure to work out a payment plan that is mutually convenient for both the office and our patients. We accept cash, personal checks, and the following credit cards: Mastercard, Visa, Discover, American Express and CareCredit. Please take a few moments to fill out a short application for the CareCredit card. It can be processed within a few minutes. Our front desk staff can provide you with the necessary information.

Insurance

Our office is happy to cooperate with patients that are covered by dental insurance. We ask that you read the policy thoroughly to ensure your understanding of any limitations concerning benefits provided.

As a service to our patients, we will gladly process and submit all forms pertaining to your dental plan but please do not ask us to falsify insurance documents in any way. Additionally, we make no guarantee of estimated coverage.

Because an insurance policy is an agreement between you and your insurance carrier, we ask that all patients accept full responsibility for all charges. Most plans pay a portion of your fee, except for preventative and diagnostic services. Whenever co-payments apply, we ask that they be paid at the time of treatment.

If you have any questions regarding our financial policy, please do not hesitate to ask for clarification. Our staff is always happy to assist you in any way we can.

I have read the above policies and agree to abide by them.

_____ _____

Patient Signature Date

HIPAA - - Health Insurance Portability and Accountability Act of 1996

I understand that, under Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and Physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken relying on this consent.

Patient name: _____

Signature: _____

Relationship to patient: _____

Date: _____

Informed Consent
Permission for Dental Examination and/or Treatment

I_____ do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Epstein and his associates, staff members, or agents, as he may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

Patient Signature_____Date_____

Witness_____