Rohini Bajaj, D.D.S.

Acknowledgement of Receipt

Of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this notice and provide it to my parent or guardian.

Please Print Name: ____

Signature: ____

Date: ____

For Office Use Only

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature in this Acknowledgement of Receipt for the Notice. Please specify if not obtained.

◊ Individual refused to sign.
◊ Parent stated that a copy was received previously prior to treatment of sibling.
◊ Communications or language barrier.
◊ Emergency situation prevented obtaining acknowledgement.
◊ Other (SPECIFY BELOW)

____

____

Received by: ____
(Staff Member)

Date: ____

DENTAL HISTORY

Date of last visit to dentist: ________________________
For what service: __________________________________
____

Has child complained about dental problems: ___________
____

Any unhappy dental experiences: _____________________
____

Any injuries to mouth, teeth, or head: ________________
____

Any mouth habit- (thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc:____________
____

Any unusual speech habits: _________________________
____

Any lost teeth: _______________________________
____

Have missing teeth been replaced: _______________
____

Orthodontic appliances worn now or ever been: ____
____

Does your child brush his/her teeth daily: __________
____

How often: __________________________________
Childs attitude towards dentistry: ________________
____
____

Do you desire complete dental services for child: ____
____

HEALTH HISTORY

Childs Physician: ___________________________________
Phone: ____

Is child under care of physician now: __________________
____

Is child receiving any medication or drugs: _______________
____

Is there any excessive bleeding when cut: _______________
____

Has child ever been hospitalized: ______________________
____

Has child ever had surgery: ______________________
____

Are there any allergies to drugs including penicillin: ___
____

Are there other allergies- Food, pollen, animals, dust, other: ____
Are there emotional problems: ___________________
____

Child hood diseases: _____________________________
____

DOES YOUR CHILD HAVE ANY HISTORY OF OR DIFFICULTY WITH ANY OF T HE FOLLOWING: MARK EACH BOX IF THE ANSWER IS "YES" AND LEAVE BLANK IF "NO".

- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ CIRCULATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ HEPATITIS
- ☐ DIABETIS
- ☐ RADIATION TREATMENT
- ☐ EPILEPSY
- ☐ KIDNEY PROBLEMS
- ☐ NERVOUS PROBLEMS
- ☐ TUBERCULOSIS
- ☐ EXCESSIVE BLEEDING
- ☐ CEREBRAL PULSAY
- ☐ SCARLET FEVER
- ☐ MALIGNANCIES
- ☐ CHRONIS SINUS
- ☐ CHRONIC EAR PROBLEMS
- ☐ ANEMIA
- ☐ ADENOIDS REMOVED
- ☐ TONSILS REMOVED
- ☐ ASTHMA
- ☐ VENERIAL DISEASE/HERPES
- ☐ AIDS

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed.
____
____
____
____
May we request release of your child's medical records for our reference? ____
Emergency contact information: Name of nearest Relative: ____
Phone: _______________________
I understand that cancellations require 24 hrs. Notice or a charge of $25 will apply.
I consent to Dental Procedures and anesthetics are necessary for the treatment of the above named patient.
I also agree to assume full Financial Responsibility for all treatment rendered. It is understood and agreed by me that I will pay all Attorney Fees and other costs necessary for the collection of any amount not paid by me when due.
It is understood that the parent accompanying the patient is responsible for payment at the time of treatment. INITIALS* ____
SIGNATURE (must be signed before treatment is rendered). ____

OFFICE USE: Update initial and date. ________ ________ ________ ________ ________

Cancellation Policy

Our current office policy reads that cancellations require a 24hr notice, or charge of $25.00 will apply. A broken appointment is caused by a patient either not showing for the confirmed time or a 24hr notice was not given. We have been very lenient with this rule in the past and have allowed 3 broken appointments before a charge was applied. Due to the amount of missed appointments we have had over the past several months we are going to need to reinforce our no show/ cancellation policies. Because we know circumstances and illnesses arise that are out of our control we will allow 1 broken appointment before a charge is incurred. Once the 2nd appointment is broken there will be a charge of $25.00 that will be strongly enforced. Also, after school appointments are prime appointments. So if you have appointments scheduled at this time and have broken more than one; we will have to limit you to any future prime appointments. Our office tries all avenues to inform you of any scheduled appointments; by doing so we always mail a reminder for all appointments. If we reach an answering machine we will leave a message and consider this a confirmed appointment. If you have another number besides your home number that would give us a better communication please let us know. This policy will begin effective immediately. We do apologize for any inconvenience this may cause.

______________________________	________________
Name of Patient	Date
______________________________	________________
Signature of Guardian	Date

CHILD'S REGISTRATION AND HISTORY

ALL BLANKS MUST BE COMPLETED

DATE: _________________

PATIENT INFORTMATION

Child's Name: ________________________ DOB: _______ M: __ F: __ Medicaid#: ____________________
Address: ____ Apt. #: ______________
City: _________________________ State: ____________ Zip: ___________ (Phone): (___) _____________
Has child seen a dentist before? _____ If yes: when, where, and were there any unfavorable experiences?

How did you find out about us? ____

FAMILY INFORMATION

Mother's Name: ___________________________________ DOB: ___________ Marital Status: M ___ S ___
Address: ____ Apt. #: ________________________
City: _______________ State: ________ Zip: ________ Phone: (___) ________ Cell/Pager: (___) ________
Email Address: ____
Social Security Number: ___________________ Employer: ____
Employer's Address: _______________________________________ City: ___________________________
State: _______________ Zip: ____________ Bus Phone: (___) __________ DL#: ______________________
Father's Name: __________________________________ DOB: ___________ Marital Status: M ___ S ___
Address: ____ Apt. #: ________________________
City: _______________ State: ________ Zip: ________ Phone: (___) ________ Cell/Pager: (___) ________
Email Address: ____
Social Security Number: ___________________ Employer: ____
Employer's Address: _______________________________________ City: ___________________________
State: _______________ Zip: ____________ Bus Phone: (___) __________ DL#: ______________________

INSURANCE INFORMATION

Insurance Company Name: ____
Claim's Mailing Address: ____
City: _________________________________ State: ________ Zip: _________ Bus Phone (___) __________
Employee ID#: ____ Group#: ___________________________

Secondary Insurance

Insurance Company Name: ____
Claim's Mailing Address: ____
City: _________________________________ State: ________ Zip: _________ Bus Phone (___) __________
Employee ID#: ____ Group#: ___________________________

INSURANCE POLICY

Thank you for choosing *Dentistry 4 Children* as your provider. We are committed to providing excellent care to our patients. As part of our professional relationship, it is important that you have an understanding of your insurance benefits and our financial policy.

PATIENTS SHOULD READ AND SIGN THIS FORM PRIOR TO RECEIVING SERVICES.

- → We must emphasize that, as your dental provider, our relationship is with you, the patient, and not youyr insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- → We may accept assignment of insurance after verification od your coverage. Please be aware that some of or perhaps all of the services provided may or may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- → Once we verify your insurance company, we will be collecting any co payments, deductibles or coinsurance amounts at the time of services.
- → Any services provided, may be applied to your deductible and or may not be covered. **If you are unsure about your insurance coverage, please ask so that we can inform you of the information received from your insurance company at the time of verification.**
- → **Failure to keep your account balance current may require us to cancel or reschedule your appointments.**

Full payment is due at the time of service. We accept cash, check, and credit cards. I have read, understand and agree to this policy.

____ ________________________

Signature of Patient, Parent, or Guardian. Date

____ ________________________

Printed Name Date