Patient ID# _____

Today's Date _____

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

_____

City _____

State/Prov. _____ Zip/P.C. _____

Phone _____

_____

Responsible Party

Name _____

Relationship _____

Address _____

_____

SS#/SIN _____

DL# _____

Email _____

Phone _____

_____

☐ Mother

☐ Stepmother ☐ Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

SS#/SIN _____

Employer _____

_____

Occupation _____

_____

DL# _____

_____

☐ Father

☐ Stepfather ☐ Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

SS#/SIN _____

Employer _____

_____

Occupation _____

_____

DL# _____

_____

Primary Dental Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Emp. _____

Occupation _____

Ins. Company _____ Group # _____ Emp. # _____

Ins. Company Address _____

Deductible _____ Amount already used _____ Max. annual benefit _____

Orthodontic coverage ☐ Yes ☐ No

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____ Employer _____

Date Emp. _____ Occupation _____

Ins. Company _____ Group # _____ Emp. # _____

Ins. Company Address _____

Deductible _____ Amount already used _____

Max. annual benefit _____

Orthodontic coverage ☐ Yes ☐ No

Parent's Marital Status

☐ Single ☐ Divorced

☐ Married ☐ Widowed

☐ Separated

Who is responsible for making appointments?

Name _____

Home Phone _____

Work Phone _____ Ext. _____

Cell Phone _____

Best time to call (Time) _____ (Days) _____

Over Please

Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous visits?_____

Does your child have history of allergies to any substances (latex, environmental, etc.)? _____

Has your child ever had any of the following:

Acid Reflux ☐ YES ☐ NO
Allergies ☐ YES ☐ NO
Anemia ☐ YES ☐ NO
Asthma ☐ YES ☐ NO
Blood Transfusion ☐ YES ☐ NO
Cancer ☐ YES ☐ NO
Convulsions/Epilepsy ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO
Handicaps/Disabilities ☐ YES ☐ NO
Hearing Impairment ☐ YES ☐ NO
Heart Problems ☐ YES ☐ NO
Hemophilia/Abnormal Bleeding ☐ YES ☐ NO
Hepatitis ☐ YES ☐ NO
HIV/AIDS ☐ YES ☐ NO
Persistent Cough ☐ YES ☐ NO
Rheumatic Fever ☐ YES ☐ NO
Tuberculosis ☐ YES ☐ NO

Please explain any medical problems that your child has

_____

_____

_____

_____

_____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Phone Number _____

Child's Birthdate _____

Is your child's water fluoridated? ..... ☐ YES ☐ NO

Does your child take fluoride supplements? ☐ YES ☐ NO

Does your child:

Suck thumb/finger ..... ☐ YES ☐ NO

Suck/Bite lips ..... ☐ YES ☐ NO

Bite/Chew nails ..... ☐ YES ☐ NO

Chew hard objects (Pencils, etc.) ..... ☐ YES ☐ NO

Grind Teeth YES ☐ NO ☐

Clench Jaws ..... ☐ YES ☐ NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor

_____

Date

Dentist's Review

_____

_____

_____

_____

Date _____

Signed Dr. _____

Health History Update

Date _____

Comments _____

_____

Signature _____

Date _____ Comments _____

_____

Signature _____

Next Generation DENTISTRY

Keeping Your Family Smiling for Generations

WELCOME to the FAMILY!

How happy are you with your current smile (1- not happy; 5- very happy)?

1 2 3 4 5 N/A

What would you like to change if possible?

_____

_____

What was one or more things you liked the best about your last dentist?

_____

_____

What was one or more things you did not like about your last dentist?

_____

_____

What are you expecting out of your visit for today? What would you like completed?

Next Generation Dentistry FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental healthcare providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement: Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using Cash, Check, Visa, Mastercard, Discover, American Express. We also offer Care Credit, which is a financing option for healthcare expenses. Returned checks will be subject to a $35.00 fee.

Payment in full with Cash or Check discount: We offer a 10% accounting courtesy for all services over $500 that is paid in full prior to commencement of services.

Care Credit: By arrangements with Care Credit, we can offer patients upon approval, no interest for 6 or 12 months with no pre-payment policy. Ask for an application.

Appointments: We try to maintain an efficient appointment system. However, our cost of providing care increases when people fail to keep scheduled appointments or cancel at the last minute. Our office requires at least a 24 hour notice for any cancelled appointments. We reserve the right to dismiss you as a patient after three missed appointments.

Insurance: Dental plan benefits are determined by your employer, not your dentist. Your dental plan policy is a contract between you and your plan company. Your plan and payment is your responsibility. A plan is not a guarantee of payment, it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your Claim for you if you present your insurance card and all required information. You will be expected to pay for services rendered if this office is unable to verify your plan information before treatment. If payment for services already rendered has not been paid in full within 90 days, either by you or your plan company, the remaining balance for treatment is considered due and must be collected from you.

Please indicate your understanding and acceptance of these financial polices by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patients Name (print)_____ **Date**_____

Patients Signature_____ **Date**_____

Next Generation Dentistry

673 East Wilbeth Road

Akron, Ohio 44306

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implantation will mail a copy of any revised notices to the address that I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and the organization is not *required* to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon to request the following restrictions to the use or disclosure of my health information.

_____Accepted _____Denied

Signature_____

Patient name_____ Date_____