Dimock,Weinberg & Cherry, DDS

PATIENT INFORMATION

Child's Full Name: ______________________ Name child goes by: ______________

☐ M ☐ F Date of Birth: ______________ Age: ______ SSN: ______________

Address: ______________________ City/State: ______________ Zip: ________

Home Number: ______________

Current School: ______________ Grade: ______ Hobbies: ______________

Please list any other siblings seen in this office: ______________________

Whom may we thank for referring you to us? ______________________

PARENT/LEGAL GUARDIAN (LG) INFORMATION

Parent/LG Name: ______________________ Relationship to patient: ______________

Date of Birth: ______________ SSN: ______________

Address (if different than patient): ______________________

Employer: ______________ Work #: ______________ Cell #: ______________

Primary Email: ______________________

Parent/LG Name: ______________________ Relationship to patient: ______________

Date of Birth: ______________ SSN: ______________

Address (if different than patient): ______________________

Employer: ______________ Work #: ______________ Cell #: ______________

Primary Email: ______________________

Who has legal custody of patient? ______________________

DENTAL INSURANCE

Policy Holder: ______________ SSN: ______________ DOB: ______________

Insurance Company: ______________ Group Number: ______________

EMERGENCY CONTACT (other than parents/guardian listed above)

Contact Name: ______________ Relationship: ______________ Contact #: ______________

AUTHORIZATION AND SIGNATURE

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dimock, Weinberg & Cherry, DDS, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payer.

____
Signature of Parent/Guardian

____
Date

Dimock, Weinberg & Cherry, DDS

PATIENT NAME: ______________________ **DATE:** ____________

HEALTH HISTORY

Name of Pediatrician: ______________________ **Pediatrician Phone #:** ____________

Please list any medications your child is currently taking:

____

____

Please list any allergies (including medication allergies):

____

____

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Condition/Murmur	☐	☐	Hemophilia	☐	☐	Epilepsy/seizures/fainting
☐	☐	Premedication Required	☐	☐	Sickle Cell Anemia	☐	☐	Down Syndrome
☐	☐	Asthma	☐	☐	Hepatitis/liver problems	☐	☐	Cerebral Palsy
☐	☐	Tuberculosis	☐	☐	Kidney disorder	☐	☐	Developmental Delay
☐	☐	Rheumatic/Scarlet Fever	☐	☐	Diabetes	☐	☐	Autism
☐	☐	HIV infection or AIDS	☐	☐	Cancer:(type)____________	☐	☐	ADHD/ADD
☐	☐	Malignant Hyperthermia	☐	☐	Vision Disorder	☐	☐	Cleft Lip or palate
☐	☐	Thyroid problems	☐	☐	Hearing Disorder	☐	☐	Latex Allergy

Please list any surgeries or hospitalizations: ______________________

____

Additional medical information: ______________________

____

DENTAL HISTORY

YES	NO		YES	NO	
☐	☐	Is this your child's first dental visit? If not, date of last visit: ________ Name of dentist:________ Were X-rays taken? ________	☐	☐	Does your child have any habits? (thumb sucking, pacifier, etc) If so, list: ________
			☐	☐	Does your child drink juice or soda? If so, how much a day? ________
☐	☐	Has your child had a bad experience in a dental office?	☐	☐	Does your child snack frequently during the day?
☐	☐	Did your child nurse or use a bottle after 12 months?	☐	☐	Has your child had a toothache or any type of oral pain recently?
☐	☐	Did/Does your child nurse or have a bottle at nighttime?	☐	☐	Has your child ever had a dental injury (bumped or chipped tooth, bruised lip)? Explain: ________
☐	☐	Do you assist your child's brushing? How often do they brush: ________			

Type of water source? ☐ Private Well ☐ City Water System

Purpose of today's visit?

____

____

I understand that the information I have given is, to the best of my knowledge, correct and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained for a parent or legal guardian before any dental services can be rendered. I understand that during my child's visit, I must remain at the office until my child is dismissed unless the office has made arrangements with my family. I give my consent to Dr. Dimock, Dr. Weinberg, Dr. Cherry and their staff to perform such treatment, services, medication, behavior management techniques, local anesthesia or analgesia to treat any dental/oral deficiency, abnormality and/or infection.

______________________ Signature of Parent/Guardian

______________ Date

WELCOME TO OUR OFFICE

Appointment Information

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give that appointment time to another patient.

- All restorative (fillings, extractions, etc.) procedures are scheduled in the morning. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.
- Our office reserves the right to charge a broken appointment fee of $45.00 for any missed appointment without prior notice of cancellation.
- Broken or missed appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 24 hours notice, our office reserves the right to NOT schedule any subsequent appointments.
- Patients who cannot be contacted by telephone or mail service for 12 months will be inactivated.

Financial Information

- We must emphasize that as health care providers, our relationship is with you, not your insurance company. While we are not participating providers with any insurance company, we will be happy to file your insurance claim provided you have all of your current insurance information.
- You will be responsible to pay any amount that is determined not payable by your insurance plan. Be aware that some services provided may be non-covered services and not considered reasonable and necessary under your dental insurance plan.
- If we have not received payment from your insurance company within 60 days after submission of a claim, you will be expected to pay for all dental services in full. In the event of duplicate payment, you will be reimbursed.
- If there is an outstanding balance on your account, please understand our office reserves the right to not schedule any subsequent appointments until the amount is paid in full.
- A charge of $25.00 will be assessed on any returned checks.
- Should your account be turned over to collections, you will be responsible for the cost of collection, without limitation, attorney's fees and court costs.

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us.

I have read and I understand the office policies and agree to abide by their contents.

____
Signature of Parent/Guardian

____
Date

Dimock, Weinberg & Cherry, DDS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name: ______________________________

Parent/Legal Guardian Name: ______________________________

Signature: ______________________________ **Date:** ______________

Relationship to Patient: ______________________________

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (Please Specify) ______________________________