GARFINKLE FAMILY DENTAL

Welcome to the office. We appreciate you choosing us for your child's dental needs.
Please fill out completely and print clearly. If you need any assistance, please don't hesitate to ask.

PATIENT INFORMATION

First Name _____ Last Name _____ Preferred Name (if different) _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth: ____ ____ / ____ ____ / ____ ____ ____ ____ Age: _____ ☐ Male ☐ Female Home Phone: _____

Mother's Full Name _____ Mother's Mobile Phone _____ E-mail (for appointment reminders) _____

Best to contact: ☐ Mother ☐ Father ☐ Either

Father's Full Name _____ Father's Mobile Phone _____

How did you first hear about our office? _____

IN CASE OF EMERGENCY CONTACT

First & Last Name _____ Relationship _____ Telephone Number _____

DENTAL INSURANCE

Will we be assisting you with filing dental insurance? ☐ No ☐ Yes [Please fill out the following and bring your card to the front to be copied]

Insurance Company Name: _____
Subscriber's Full Name: _____
Subscriber's Date of Birth: ____ ____ / ____ ____ / ____ ____ ____ ____
Subscriber's SSN or ID: _____

DENTAL/MEDICAL HEALTH HISTORY

By checking the box, you indicate a "**Yes**" response and leaving it blank indicates a "**No**" response.

- ☐ Had problems w/previous dental treatment?
- ☐ Does your child gag easily?
- ☐ Does food catch between their teeth?
- ☐ Do they have difficulty chewing?
- ☐ Do they chew on only one side of the mouth?
- ☐ Do they avoid brushing any particular area?
- ☐ Do their gums bleed easily?
- ☐ Do their gums bleed when they floss?
- ☐ Do their gums feel swollen or tender?
- ☐ Have you ever noticed slow-healing sores?
- ☐ Does your child brush their teeth? ____/day
- ☐ Does your child floss? ____/day ____/week
- ☐ Does their jaw make noise?

Please List Any **Allergies**:

- ☐ None
- ☐ Aspirin, Acetaminophen or Ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Latex or other rubber(s)
- ☐ Local Anesthetics ("Novocaine")
- ☐ Penicillin/Amoxicillin/other antibiotics
- ☐ Reaction to Metals
- ☐ Other(s):

_____
_____
_____

Are your child's teeth sensitive to:

- ☐ Hot foods or liquids?
- ☐ Cold foods or liquids?
- ☐ Sours?
- ☐ Sweets?
- ☐ Crunchy?

Please rate the following, **1 to 4**, 1 being the *most* worrisome and 4 being the *least* worrisome to you regarding your child's dental treatment:

- ☐ Taking **time** off of school/work
- ☐ The **cost** of treatment
- ☐ They have a **fear** of pain/dental work
- ☐ Possibility of them **losing teeth**

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DENTAL/MEDICAL HEALTH HISTORYCONT.

Does your child have, or have ever had any of the following?

By checking the box, you indicate a "**Yes**" response and leaving it blank indicates a "**No**" response.

☐ Anemia	☐ Head Injury	☐ Radiation Treatment
☐ Arthritis	☐ Headaches (Frequent/Severe)	☐ Respiratory Problems
☐ Artificial Joints	☐ Heart Disease	☐ Rheumatic Fever
☐ Asthma	☐ Heart Murmur	☐ Rheumatism
☐ Blood Disease	☐ Hepatitis (A, B or C)	☐ Seizures
☐ Bone/Joint Problems	☐ High Blood Pressure	☐ Sinus Problems
☐ Cancer	☐ HIV (Human Immunodeficiency Virus)	☐ Stomach Problems
☐ Diabetes	☐ HPV (Human Papillomavirus)	☐ Stroke
☐ Dizziness	☐ Jaundice	☐ Thyroid Problems
☐ Easily Bruise	☐ Kidney Disease	☐ Tuberculosis
☐ Epilepsy	☐ Liver Disease	☐ Tumors
☐ Excessive Bleeding	☐ Mental Disorder(s)	☐ Ulcers
☐ Fainting	☐ Nervous Disorders	☐ Venereal Disease
☐ Glaucoma	☐ Pacemaker	☐ _____

☐ Premedication required by a physician ☐ GIRLS: Are you taking any form on contraceptive

Please List Any Current **Medications**: ☐ None

☐ _____

_____

_____

_____

If your child currently under the ongoing care of a physician (for more than routine checkups)? ☐ No ☐ Yes

If you chose Yes, please provide their name and phone number: _____

_____

Please note they will be asked each visit if there has been any changes or additions to this medical history, and it is imperative you let us know if anything changes so we can continue to provide them the most comprehensive dental care.

Please go to the next page >

OFFICE POLICIES

Dear Newest Member of the Garfinkle Dental Family,

Thank you for selecting us as your child's dental health care provider, we are very happy to have them as a new patient! At Garfinkle Family Dental, we take a lot of pride in meeting and exceeding our patients' needs. This keeps us very busy, so we do require each new patient/guardian read and understand the following office policies. If you have any questions/concerns, please do not hesitate to ask our Office Manager.

As a condition of your treatment by this office, financial arrangements must be made in advance and the required payment is due the date the services are started. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment is provided. For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit Healthcare Financing. Any returned checks will have an additional $25.00 fee.

As a courtesy for our patients who carry dental insurance, we will verify your eligibility and file claims on your behalf. This means you will only be responsible for estimated co-payments for your visits and we will bill and accept payment from your insurance company. We need you to understand that due to insurance guidelines, it is impossible for us to estimate your dental coverage at 100% accuracy until we become more familiar with your policy. Any treatment estimate we provided is exactly that, an estimate. Although we surely do our best to be as precise as possible, any balance that remains after your insurance does or does not pay is ultimately your responsibility. Any balance remaining must be paid in full within 45 days. Balances older than 90 days are subject to additional collections fees. We understand financial difficulties may affect timely payment of your balance, so we encourage you to communicate such problems to us so that we can assist you in the management of your account.

This office utilizes both text and email in addition to reminder and confirmation phone calls. If you provide us with either a cell phone number or email and signing below, you are granting us permission to contact you via these methods for appointment reminders/confirmations. We do not share, sell or distribute any of your information without your prior knowledge and/or consent. (See our Privacy Practices for details on how we protect your information).

☐ Check this box if you **DO NOT** want to receive appointment reminder **emails**.
☐ Check this box if you **DO NOT** want to receive appointment reminder **text messages**.

Again, because we want to best serve our patients, we adhere to a strict policy regarding no-show and failed appointments. We consider an appointment "*failed*" if enough notice is not given so we can fill the appointment time with another patient in need. That being said, ***we require at least two business days' notice*** to change or cancel a scheduled appointment. Each and every team member takes time to prepare for each and every appointment. We're sure you understand that when you fail an appointment that has been set aside specifically for you, it not only hurts the office but other patients who could have been seen at that time. We reserve the right to charge a $50.00 failed appointment fee for these instances.

I have read the above policies, conditions of treatment and payment guidelines and agree to abide by them:

_____ _____
Print Name of Patient Date

_____
Signature of Parent/Guardian

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Garfinkle Family Dental protects your personal health information (PHI) with the utmost care and responsibility. We have established a clear notice to all patients on how exactly we do that. This notice is displayed publicly in our waiting room and you are welcome to request a copy to take home.

By signing this, I acknowledge I have had the opportunity to read and ask any questions I may have regarding this office's Privacy Practices and how they are protecting my confidential health and personal information.

✔ _____
Print the Patient's Name

✔ _____
Print Name of Parent/Guardian

✔ _____
Signature

✔ _____
Date

[FOR OFFICE USE ONLY]

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

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ Other (Please Specify):_____