*We welcome your child to*

***Schwartz Dentistry for Children* and Young Adults!**

**AARON B. SCHWARTZ DDS MPH**

Patient_____Today's Date_____
Name child would like to be called_____Home Phone_____
Date of birth_____Age_____Sex_____Cell phone_____
Guardian's Email_____
Home Address_____
Street city state zip code

Guardian 1:_____Relation to patient_____
Employer_____Phone_____
Guardian 2:_____Relation to patient_____
Employer_____Phone_____
Who has legal custody of patient?_____
Person responsible for payment
Of account_____Dental insurance: Yes NO
**Last 4 digits** of SS#_____Date of Birth_____
Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit?_____

**Health History**

**Yes** **No** Is your child in good health? Date of last physical exam_____
**Yes** **No** Has your child ever had a health problem?_____
**Yes** **No** Has your child ever been hospitalized? Please give reason and dates_
_____
**Yes** **No** Is your child allergic to **any food or medication**?_____
**Yes** **No** Is your child currently taking any medications? Please give medication
Dose and reason_____
**Yes** **No** Were there any problems at birth?_____

**Please circle if your child has been treated for any of the following:**

| | | | |
|---|---|---|---|
| Heart disease | Bleeding/transfusions | Asthma/breathing | Blood dyscrasias |
| Liver/GI disease | Anemia | Diabetes | AIDS |
| Kidney disease | Rheumatic fever | Hepatitis | Mental delays |
| Speech/hearing | Seizures | Cleft lip/palate | Physical delays |
| Eyesight | Congenital birth defects | Personality/social | Other problems |
| Cancer/tumors | Recurrent headaches | Frequent infections | Adverse Drug reactions |
| Cerebral palsy | Significant injuries | Endocrine/growth | Autism |

Please give details on any items circled:_____

**-OVER-**

## Dental History

Yes No Has your child previously seen a dentist?
Name of dentist and date_____

Yes No Has your child experienced any unfavorable reaction from previous Dental care? Explain_____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Is your child experiencing any jaw pain?

Yes No Does your child have any dental problems that you are especially concerned About? If yes please explain_____
_____

**Who is your child's pediatrician?**

_____

## CONSENT FOR DENTAL TREATMENT

I request and authorize *Dr. Aaron Schwartz* and associates to examine and provide dental treatment on my child's teeth. I further request and authorize, as deemed necessary, dental radiographs to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. *Dr. Aaron Schwartz* and associates will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

I hereby authorize any payment of dental benefits to be made directly to *Schwartz Dentistry for Children*. I also understand that any amount not covered by my insurance policy is my responsibility and is due at the time of treatment. I authorize treatment to be rendered and I assume financial responsibility. I acknowledge that all non-current balances and accounts over 60 days will be charged a service charge of 1.5% per month (18% per year) on the unpaid balance. The cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to the balance due.

**(INITIAL)**

_____I acknowledge the notice of privacy policies and understand that I may receive a copy upon request.

_____I understand I may refuse to sign this acknowledgement.

SIGNATURE_____DATE_____

**Schwartz Dentistry for Children, PC** **Dr. Aaron Schwartz**

# HIPPA
# PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change his form, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, b if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent, if writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**The Patient Understands that**:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- This Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will the cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____
Printed Name: Patient or Representative

_____ _____
Signature Date

Relationship to Patient: _____

# Schwartz Dentistry for Children: Office Policies

## Broken Appointment Policy

Your scheduled appointment is reserved specifically for your child. Any change in this appointment affects all of our patients. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give that time to another patient. We will make every effort to try to confirm your child's appointment. **In the event that we do not receive at least 24 hours notice, you may be subject to a $50.00 broken appointment fee.** If two (2) broken/missed appointments or two (2) cancellations without 24-hour notice occur, our office reserves the right to NOT schedule any subsequent appointments. Also, if you arrive 15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time. Again, please call at least 24 hours in advance if a cancellation is unavoidable so that we may give the appointment to another patient.

## Parents in Treatment Area

We strive to achieve a balance between allowing parents to be a part of their child's dental experience and allowing children to feel comfortable and confident enough to undergo dental treatment on their own. With this in mind, parents are invited back to observe during the initial examination or during any emergency examination. Additionally, a parent is welcome to accompany a child to any subsequent treatment appointments. However, if we feel that your presence is having a negative impact on your child's behavior, you may be asked to step away from your child's field of vision or not accompany your child. We strongly encourage you to allow your older children to undergo their dental experience on their own. This arrangement allows the doctor and staff to communicate with your child directly without distractions, and may result in a more positive experience for your child. If we feel that your presence will benefit your child, we may ask you to join us in the treatment area. If you would like to otherwise accompany your child into the treatment area, we will accommodate your request, but ask that you schedule a morning appointment. Please let our receptionist know if you request special accommodations.

For safety and privacy of the other patients, all others (including children that are not scheduled at this appointment) are asked to remain in the reception room. Young children in the reception room will need a supervising adult.

## Financial policy

Our office will attempt to verify your insurance coverage prior to each appointment and advise you if there are any routine services, which are not covered. This is not always possible and sometimes the information that we receive from the insurance company is inaccurate. Your estimated portion will be due at the time of treatment. **In the event that your insurance company does not reimburse our office as expected, you will be responsible for any remaining balance.** We encourage you to contact your insurance company prior to your child's visit if you have any questions regarding this matter. We are happy to assist you in any way in understanding and maximizing your benefits.

I have had an opportunity to review the office policies and accept the terms:

_____ _____

Parent/Guardian Signature Print name

**Schwartz Dentistry for Children, PC** **Dr. Aaron Schwartz**

# FINANCIAL RESPONSIBILITY FORM:

- ***A legal parent/guardian responsible for the patient must sign this form; this is not an insurance form.***

Patient's Name: _____ DOB: _____

I understand that I am financially responsible for all services rendered by associates of ***Schwartz Dentistry for Children***.

Those who carry dental insurance understand that all dental services furnished are charged directly to the legal guardian of the patient and that he/she is personally responsible for payment of all dental services *not covered by insurance*.

Please note that proof of eligibility of insurance is required at the time of service. (*This information does not guarantee or imply payment and is contingent upon other factors, including but not limited to eligibility changes, covered services and benefit limitations)*

**Parent/Guardian Signature** _____

**Print Name** _____

**DATE** _____