central jersey
pediatric dentistry & orthodontics llc

176 summerhill road
east brunswick, nj 08816-3063

www.kiddent.com

732-257-5588 • Fax 732-257-9189

ACCOUNT INFORMATION

Full Legal Name of Child ______________________ Birthdate __________ Sex ___
Home Address ______________________ Home Phone # __________

Father's Name ______________ Social Security # ______________ Birthdate ______________
Address ______________ Home Phone # ______________ Cell Phone # ______________
______________ Employer ______________ Work Phone # ______________
Email ______________ Occupation ______________

Mother's Name ______________ Social Security # ______________ Birthdate ______________
Address ______________ Home Phone # ______________ Cell Phone # ______________
______________ Employer ______________ Work Phone # ______________
Email ______________ Occupation ______________

Who may we thank for referring you to our office? Name ______________
Address ______________

Names and ages of other children in the family ______________________

____

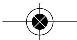
MEDICAL INFORMATION

1. Your child's health is: Excellent ________ Good ________ Fair ________ Poor ________
2. Name of child's Pediatrician / Physician ______________________ Phone # ______________
3. Is your child taking any medications at present? Yes _______ No _______
   If yes, what are the names of the medications ______________________
   ____
4. Has your child ever had an unfavorable reaction to a local (Novocaine) or general (gas) anesthetic? Yes _______ No _______
   If yes, please describe the situation ______________________
   ____
   ____
5. HAS YOUR CHILD EVER BEEN ALLERGIC TO ANY MEDICINE, FOOD, OR SUBSTANCE?
   If so, please list ______________________
6. Has your child had any bleeding problems? ______________________
7. Has your child had any history of the following:

____ ADHD	____ Cerebral Palsy	____ Digestion	____ Hearing	____ Mumps
____ Anemia	____ Chicken Pox	____ Down's Syndrome	____ Heart	____ Muscular Dystrophy
____ Asthma	____ Chronic Sinus	____ Ear Infection	____ Kidney	____ Rheumatic Fever
____ Autism	____ Colds	____ Epilepsy	____ Liver	____ Skin Disorders
____ Bladder	____ Convulsions	____ Fainting	____ Measles	____ Thyroid
____ Cancer	____ Diabetes	____ Glands	____ Mononucleosis	____ Tuberculosis

   ____ Other ______________________
8. Please comment on any of the above checked items if you feel it is significant ______________________
   ____
9. Has your child ever had any hearing, sight, speech, coordination, or special schooling problem? ______________
   If so, please describe ______________________
10. Was the term of pregnancy and birth normal with respect to your child? ________ If not, then please state any complications or problems including prematurity, low birth weight, or medications taken ______________________
    ____
11. Can you offer any other information about your child or family's health which may help us in providing them with appropriate dental care?
    ____

Please visit our website www.kiddent.com for office hours and directions to our office.



DENTAL INFORMATION

1. Family Dentist ______________________ Child's Previous Dentist ______________________
2. What is your reason for bringing your child to this office? ______________________
____
3. Is this your child's first visit to a dentist? ______________________
If not, when was the last visit? ______________ Was any treatment done? ______________
4. Date of last dental x-rays ______________ By whom? ______________
5. Has there been a problem associated with previous dental care? ______________________
____
6. Does your child take fluoride supplements: Yes ______ Name ______________ Dosage ______
7. Does your child have a history of:
____ Thumbsucking ____ Object or Nail Biting ____ Tongue Thrusting ____ Other ______________
____ Mouth Breather ____ Bed Wetting ____ Speech Problem ______________
8. Has any member of your family had any unusual dental problem? ______________________
____
9. Has there ever been an injury to your child's teeth or mouth? ______________________
____
10. At what age did your child's teeth first appear? ______________________
11. At what age was your child taken off the bottle? ______________________
12. At what age did your child walk? ______________ Talk? ______________
13. How often does your child brush his/her teeth? __________ Supervised? ______________
14. Are you concerned about any special dental problems now? ______________________
____
15. Is your child experiencing any dental pain or discomfort now? ______________________
16. What do you think of the condition of your child's teeth? ______________________

PERSONAL INFORMATION

1. Name of School ______________________ Grade______
2. Child's interests, hobbies, talents, etc. ______________________
____
3. Is your child in a special education program? Yes ______ No ______
4. Please describe your child's temperament:
____ Shy ____ Fearful ____ Manipulative ____ Requires special understanding
____ Easygoing ____ Calm ____ Outgoing
5. Can you offer any other information about your child's emotional and developmental status which could help us in giving your child the best dental experience and care? ______________________
____
____
____
6. Please list any questions you would like to have answered
1. ______________________
2. ______________________
3. ______________________
4. ______________________

CENTRAL JERSEY PEDIATRIC DENTISTRY AND ORTHODONTIC, LLC PRACTICE INFORMATION

We make every effort to inform parents of the fees for any treatment prior to the scheduled appointment. If you should have any questions about the fees for your child's dental treatment please speak to our office personnel prior to beginning such treatment. Payment is due at the time services are rendered. The adult bringing the child in for their treatment should be prepared to make the necessary payment for these services. We offer financial arrangements for extensive dental or orthodontic treatment. Our office gladly accepts cash, checks, American Express, Discover, Master Card and Visa.

Account statements are sent on a regular basis and payment is due within 14 days of receipt. There will be a 1 1/2% monthly service charge on any amount due over 30 days. Any account sent to a collection agency will incur an additional 25% collection fee and all necessary attorney/legal fees. A broken appointment fee may be charged for any appointment cancelled or missed without 24 hour notice.

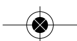
CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby give Central Jersey Pediatric Dentistry and Orthodontics, LLC permission to render any necessary dental treatment. I assume full financial responsibility for these services and acknowledge that I have received a copy of Central Jersey Pediatric Dentistry and Orthodontics, LLC Notice of Privacy Practices.

Signature ______________________ Print Name ______________________ Dated ______________

12-116 ACCOUNT INFORMATION

11-052 Ins Verification_Layout 1 5/25/11 2:32 PM Page 1



central jersey
pediatric dentistry & orthodontics llc

176 summerhill road
east brunswick, nj 08816-3063

www.kiddent.com

732-257-5588 • Fax 732-257-9189

Name ______________________ Account # ____________ Date __________

INSURANCE VERIFICATION

New Jersey law requires us to disclose all of the following information on any claims submitted.

Primary:

Insured's Name ______________________ Birth Date ____________
Address ______________________ SS # ____________
Employer Name ____________ Employer Phone # ____________
Employer Address ______________________
Insurance Company: Name ______________________
Effective Date ______________________
Address ______________________
____
Tel No. ______________________
ID # ____________ Group/Plan # ____________

Secondary:

Insured's Name ______________________ Birth Date ____________
Address ______________________ SS # ____________
Employer Name ____________ Employer Phone # ____________
Employer Address ______________________
Insurance Company: Name ______________________
Effective Date ______________________
Address ______________________
____
Tel No. ______________________
ID # ____________ Group/Plan # ____________

If any dependent child is over the age of eighteen please supply the following:
Name of child ______________________
Name of F/T school attending ______________________

Please be advised that our office only processes your primary insurance claims. Once your primary insurance has paid us, **you** assume full financial responsibility for any balance remaining. It is also your responsibility to process any claims needed for your secondary insurance. The above secondary insurance information is for disclosure purposes only.

Insurance Assignment of Benefits

I hereby authorize release to my insurance carrier any information related to claim submitted on my/or my children's behalf to such insurance company. I also authorize and direct payment of the dental benefits otherwise payable to me, directly to Central Jersey Pediatric Dentistry and Orthodontics, LLC.

Insured Signature: ______________________ Dated: ____________

Print Name: ______________________

CREDIT CARD AUTHORIZATION

Responsible Party	Patient Name(s)
CARD HOLDER'S NAME	NAME OF CREDIT CARD Visa / MasterCard / Discover American Express
ADDRESS	ZIP CODE
CREDIT CARD #	EXPIRATION DATE
V CODE (last 3 digits on the back of the card)	INVOICE # (last 4 digits of cc #)

This document authorizes our office to charge your credit card for any services rendered. If this office is not able to process your payment responsibility due to the card being terminated or declined either directly or indirectly by you, the following action will be taken:

1. 1 and 1/2% interest will be added to account retroactive for any balance past due 30 days until we are able to process payments to an authorized credit card.

2. All future appointments will be put on hold until this situation is resolved.

This agreement may only be terminated by written request and will not be retroactive. You are required to inform us of any changes to your credit card status immediately.

CARD HOLDER'S SIGNATURE	DATE

11-052 Ins Verification_Layout 1 5/25/11 2:32 PM Page 2

CENTRAL JERSEY PEDIATRIC DENTISTRY & ORTHODONTICS, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of per (including identifying or locating) a family member, your personal representative for another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._______ for each page, $_______ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or two alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you received this Notice on our Web site or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Kathy Aptaker**

Telephone: **732-257-5588** Fax: **732-257-9189** E-mail: **cjpdo5@hotmail.com**

Address: **176 Summerhill Road** City: **East Brunswick** State: **NJ** Zip: **08816**

© 2002 American Dental Association

All Rights Reserved. Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).