WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Business Phone _____ Cell Phone _____ Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Child _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from child)* _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____ Insurance Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Child _____ Birthdate _____

Address *(if different from child)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____ Insurance Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do for your child today? _____

_____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems?

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Child's habits affecting the mouth or teeth: ❑ Thumb sucking ❑ Nail biting ❑ Other _____

Other information about your child's dental health or previous treatment _____

_____

Medical History

Child's Physician _____ Phone _____

Physician's Email _____

Date of last visit _____ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Is your child currently under physician care? ❑ Y ❑ N If yes, describe _____

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Has your child ever taken Fen-Phen/Redux? ❑ Y ❑ N

Check (✓) yes or no whether your child has had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anemia
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chicken Pox
❑ Y ❑ N Convulsions/Epilepsy
❑ Y ❑ N Cough, persistent

❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Headaches
❑ Y ❑ N Hearing Impairment
❑ Y ❑ N Heart problems
Describe _____

❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Immunizations current
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever

❑ Y ❑ N Shortness of breath
❑ Y ❑ N Sinus problems
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Other
Describe _____

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

FLOWER HILL DENTAL GROUP

Michael Azrolan, D.D.S.
Renee Choe, D.D.S
Effie Ahladiotis, D.M.D.
Erica Sutter, D.D.S

Lee Nissensohn, D.D.S.
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FINANCIAL POLICY

We would like to advise you that having insurance coverage does NOT indicate being covered at 100% for all services. Whereas some procedures may be paid in full, most of your treatments will be covered at a percentage of the charge. It is **your** responsibility to pay any co-payment amount and/or a deductible according to your insurance policy. If for any reason your insurance does not pay their portion within 60 days after your procedure, you will be responsible for that part as well.

In order to control our billing costs, we request that your portion of the charges be paid at the end of each visit unless other arrangements are made in advance. Please note that you will also be responsible for any service not covered or denied by your insurance company.

For your convenience, we will accept cash, checks and all major credit cards. Checks returned for insufficient funds will be charged a $35.00 fee.

Because of the nature of our practice, we reserve a specific amount of time for each patient depending on the treatment. This time is extremely valuable to us. Appointments cancelled without a 24-hour notice will incur a $50.00 broken appointment fee. Accumulation of broken appointments may lead to our refusal to accept you as a patient.

If you have an outstanding balance over 90 days, a finance charge will be applied to your account according to New York State laws, unless you have a payment plan with us. Please do not hesitate to ask us about financial arrangements that we can offer to help you pay off large balances.

_____ _____

Patient's Signature
(Parent/guardian if minor)

Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed name: _____

Relationship to patient: _____

Signature: _____

Date: _____

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