CHILD

Kreiner Pediatric Dental, L.L.C.

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Paramus, New Jersey 07652
(201) 556-0006
www.kreinerdental.com
NJ Spec. Permit #5606 & 5608

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:

Name: _____ Date of Birth: _____
Home Phone #: _____ Cell Phone #: _____ (Mom, Dad)
Business Phone #: _____ (Mom, Dad) (*Please circle preferred number)*
Responsible party:_____
Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Whom may we thank for referring you? _____
Notify in case of emergency _____

PRIMARY DENTAL INSURANCE:

Person Responsible for Account: _____
Relation to Child: _____Date of Birth: _____Social Sec. Number: _____
Address (if different from child): _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Phone #: _____
Group #: _____ Subscriber #: _____

SECONDARY DENTAL INSURANCE:

Policy Holder: _____
Relation to Child: _____Date of Birth: _____Social Sec. Number: _____
Address (if different from child): _____
City: _____ State: _____ Zip Code: _____
Employer: _____Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____Phone #: _____
Group #: _____ Subscriber #: _____

DENTAL HISTORY:

Is this your child's first visit to the dentist? _____Yes _____No

What is the purpose of today's visit? _____

How many times a day does your child brush? _____
Does your child floss? _____ Yes _____ No
Is your child using a bottle? ___ Yes ___ No If yes, what are the contents? _____
If not, at what age was the bottle discontinued? _____
Is your child currently breastfed? _____Yes _____No
Does your child take vitamins supplemented with fluoride? ___ Yes ____ No

Does your child have any of the following habits? (please circle)
Finger/thumb sucking Pacifier Use

Is your child currently having any dental discomfort? _____Yes _____ No
If yes, please explain: _____

Has your child ever had previous dental treatment? _____ Yes _____No
If yes, please explain: _____
Name of dentist? _____

Is your child currently being treated by an orthodontist? _____Yes _____No
Name of orthodontist: _____

How does your child behave with the pediatrician? _____

MEDICAL HISTORY:

Date of Last Check up: __/__/__
Name of Pediatrician: _____ Phone #: _____
Address: _____ Suite #: _____
City: _____ State: _____ Zip Code: _____

Has your child been diagnosed with any of the following? Please circle all that apply:

ADD/ADHD	Allergies	Anemia
Asthma	Autism	Bleeding Disorders
Cardiac Conditions	Diabetes	Cancer, Malignancies, Tumors
Ear Infections	Fainting	Hearing Loss
Heart Murmur	Intestinal Problems	Learning Disability
Speech Delay	Thyroid Problems	Liver Disease/Hepatitis
Respiratory Problems	Renal/Kidney Disease	Seizure Disorder
Sinus Problems	Tuberculosis	Visual Disorder
Muscular Coordination Disorder (CP)		Rheumatic Heart Disease

Has your child had any disease or medical issue not mentioned above? ___ Yes ___ No
If yes, please explain: _____

Has your child ever been hospitalized? ___ Yes ___ No
If yes, please explain: _____

Was the term of your pregnancy and the birth of your child normal? ___ Yes ___ No
If not, please explain: _____

Is your child taking any medications? ___ Yes ___ No
If yes, please list name(s) and dosage: _____

Has your child had an unusual experience with any anesthetic? ___ Yes ___ No
If yes, please explain: _____

Has your child had an unfavorable reaction or allergy to:
Food, drugs, latex or medications ___ Yes ___ No
If yes, please explain type of reaction: _____

CONSENT FOR TREATMENT

I hereby give my consent to Geri Kreiner-Litt, D.D.S. and Michelle Kreiner-Lieberman, D.D.S. and their associates to treat my child. I authorize the treating dentist to provide any information to other doctors for the purpose of consultation. I understand that prior to providing any treatment I will be advised about it by the dentist or hygienist, that I may ask questions concerning it, and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of the patient.

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 responsible for all charges whether or not paid by insurance.

Parent's Signature: _____
Parent's Name: _____ Date: _____

****For any future appointments, if you are planning to send your child with someone other than a legal guardian, please provide the following information:

Name of authorized person: _____

PATIENT HIPAA AWARENESS

I have been provided the Kreiner Pediatric Dental Notice of Privacy Practices and have been offered a copy of such policy to keep for my records.

I hereby give permission for this office to leave messages on my voicemail/email at
___ My home (please initial) ___ ___ My Cell (please initial) ___
___ My office (please initial) ___ ___ Email/text (please initial) ___

I hereby give the following people permission to receive information from this office on my behalf:

_____
Name of Person Relationship to me (e.g. Parent, friend, spouse)

_____
Name of Person Relationship to me (e.g. Parent, friend, spouse)

Signature Patient/ Legal Guardian: _____ Date: _____

FINANCIAL POLICY:

We are delighted to welcome your child to our practice and we are pleased that you chose us to serve your child's dental needs. The following is a statement of our financial policy, which we require you to read and sign at the bottom of this page:

Payment is expected at the time that services are rendered and is the responsibility of the accompanying adult.

PAYMENT METHODS:

We accept Visa, Mastercard, American Express, Discover, Care Credit, Cash, and Personal Checks*

*All returned checks are subject to a fifty dollar ($50) service charge.

DENTAL INSURANCE:

Our office is committed to helping you maximize your insurance benefits. Because dental insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. As a courtesy, Kreiner Dental will contact your insurance prior to your child's visit to estimate your patient portion. However, it is NOT the responsibility of Kreiner Dental to know your insurance coverage. It is your responsibility to know your insurance plan and covered benefits and to inform us of any changes to your insurance coverage. As a service to our patients, we will submit claims to your insurance company and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance.

Your estimated deductible and co-payment are due at the time services are rendered. Although we try our best to estimate as accurately as possible, the final amount your insurance will pay is not determined until they issue a claim check to us. You are responsible for all balances not paid by your insurance carrier. If your account is over 90 days past due, a $50 collection agency fee will be added to the account.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

Parent's signature: _____ Date:_____
Parent's name: _____

Insurance facts you should know:

- Many insurances have more than one plan and fee schedules.
- Most dental plans have exclusions, frequency and age limitations on procedures including fluoride treatments, sealants, space maintainers, emergency examinations and fillings. Emergency examinations may be grouped with your yearly limit of examinations. Make sure to check your plan and be familiar with their exceptions. You may ask our front desk to provide a copy of your dental benefits.
- Most insurances will provide us with an estimate of benefits. This is not a guarantee of payment.