Klockner Road Office, 2929 Klockner Road, Hamilton Square, NJ 08690 (609) 586-6603
Merrill Lynch Campus, 1300 Merrill Lynch Drive 0301, Pennington, NJ 08534-4122 (609) 274-8484
Kuser Road Office, NJ Family Care, 2501 Kuser Road (2nd Floor), Hamilton Township, NJ 08691 (609) 689-1212

CHILD'S HEALTH HISTORY

Child's Name: _____Nickname:_____Date of Birth:_____

Age: _____ Sex: **M F** Height: _____ Weight: _____ Parent's marital status: **M S SEP D W**

Race: _____ Ethnicity: _____ Language Preference:_____

Name of dental insurance, if any: _____ID#_____

Other children in family (name and ages): _____

Child's Physician:_____Former Dentist:_____

Whom may we thank for referring you to our office? _____

1. Does your child have any history of [ ] Heart Trouble, [ ] Emotional, Nervous or Learning Disorder, [ ] Allergies, [ ] Diabetes, [ ] Brain Injury, Kidney, or Liver Involvement, [ ] Seizure or Convulsions, [ ] Bleeding Disorder, [ ] Other? _____ **Yes No**

2. Has your child ever been in the hospital overnight, or had any operation? If yes, for what? **Yes No**

_____

3. Is there anything concerning your child's medical history which you feel may be important? **Yes No**

_____

4. Does your child have any allergies? _____ **Yes No**

5. Has your child experienced any unfavorable reaction from previous dental or medical care? **Yes No**

_____

6. Does your drinking water have fluoride? _____ **Yes No**

7. Does your child have any mouth habits, such as [ ] Finger or Thumb Sucking, [ ] Lip Biting, [ ] Other? _____ **Yes No**

8. Is your child under medical care at the present? _____ **Yes No**

9. Is your child taking medication? _____ **Yes No**

10. Does your child smoke? If so, how many a day? _____ **Yes No**

11. Is there anything you feel we should know about your child? _____ **Yes No**

continued on next page...

I hereby authorize and direct the dentists of Hamilton Dental Associates, assisted by other dentists and/or dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) dental services that in their judgment are advisable with exception of _____

_____

_____

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown or extracted tooth, injury to the tongue, lips or cheek, damage to and the possible loss existing teeth and or fillings, injury to nerves near the treatment site and fracture to a tooth which may need additional treatment or surgery.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it. If there is ever a change in my child's health, I will inform the doctor at the next appointment.

Signature, Relationship and Date: _____

Account #: _____

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CHILDREN'S CONTACT INFORMATION

Date:

Children's Name(s) Date of Birth:

_____ _____ / _____ / _____
_____ _____ / _____ / _____
_____ _____ / _____ / _____
_____ _____ / _____ / _____

Primary Guardian (*Last*): _____ (*First*): _____

Relation to patient(s): _____

Home Address: _____ Apt/Suite/Unit: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ / _____ / _____ SSN: _____ - _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Employer: _____ Occupation: _____

Work Phone: (_____) _____ - _____ ext: _____

Spouse/Secondary Guardian: (*Last*) _____ (*First*): _____

Relation to patient(s): _____

Date of Birth: _____ / _____ / _____ SSN: _____ - _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Employer: _____ Occupation: _____

Work Phone: (_____) _____ - _____ ext: _____

Person Responsible for Account: _____ Power of Attorney: _____

Preferred Method of Contact: Cell Text Home Work

Parent's Marital Status: Single Married Divorced/Seperated

Name of Dental Insurance, if any: _____

Secondary Dental Insurance, if any: _____

Whom may we thank for referring you to our office? _____

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DENTAL AND MEDICAL INSURANCE INFORMATION

Today's Date: _____ / _____ / _____

Primary Dental Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Dental Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Dental Insurance Company Phone Number: ( ) _____-_____

Secondary Dental Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

I have been informed of the treatment plan and associates fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

*Sign*_____*Date:* _____/_____/_____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Hamilton Dental Associates.

*Sign:*_____*Date:* _____/_____/_____

Please bring your Dental and Medical Insurance cards with you on your visit

continued on next page...

Secondary Dental Insurance (continued)

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Dental Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Dental Insurance Company Phone Number: ( ) _____-_____

Primary Medical Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Medical Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Medical Insurance Company Phone Number: ( ) _____-_____

Secondary Medical Insurance

Patient's Name(s) :_____

Patient's Address:_____City:_____State:_____Zip:_____

Name of person who carries the insurance: _____Date of Birth: _____/_____/_____

Marital Status: **Single, Married, Divorced, Separated**

Employee Address:_____City:_____State:_____Zip_____

**If separated or divorced make certain you give the correct mailing address and phone number of the person who carries the insurance and with whom the patient resides.*

Employee Social Security Number:_____-____-_____

Place of Employment:_____

Insurance Group Number:_____

Identification Number:_____ Effective Date: _____/____/_____

Medical Insurance Company Name:_____

Mailing Address of Insurance Company:_____

Medical Insurance Company Phone Number: ( ) _____-_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

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Financial Policies for Hamilton Dental Associates

Recently, we have seen continuous changes in the insurance plans of our patients. Managing insurance claims on behalf of our patients has become increasingly intricate in the current dental landscape of ever changing plans and benefits. *In order to serve you properly, it is essential that you provide us with the most detailed and updated information concerning your dental insurance(s). (For example, Aetna Insurance now has hundreds of different dental sub-plans, all with differing benefits.)*

Hamilton Dental Associates is not an agent of, nor is it associated with, any dental insurance company. The ultimate responsibility of determining and understanding the details, restrictions and limitations of your insurance is yours. As a courtesy to our patients, we currently are happy to provide the service of completing, submitting and receiving payments from your insurance company; however, **it is important that you understand that any pre-estimate, either determined by our office or by your insurance company is not a guarantee of payment. Further, these estimates are subject to changes made by your insurance company during claim processing**. Insurance benefits, used to create our office's estimates, are determined by many criteria including but not limited to, your eligibility at the time of treatment, any noted deductibles, and yearly or family maximums. **We cannot guarantee payment from an insurance carrier, nor be held responsible for multiple inquiries, requests or refusals made by insurance company(s) during claim processing. All fees for your treatment are your responsibility, not that of any insurance company or policy**. Unless payment arrangements have been made in advance, payment for services is expected at the time of treatment. Unpaid patient balances are subject to placement with a third party collection agency, and will incur a 25% collection processing fee.

For our patients with dental insurance, signing this form, in addition to understanding the above, gives our office permission to provide your insurance carrier with information from your dental records, which may assist in processing your claims. As part of the contract with your insurance carrier, patients also agree that insurance payments for dental services performed by Hamilton Dental Associates will be directly endorsed to our office. If, for any reason, insurance payments are issued to the patient directly, it becomes the patient responsibility to endorse these payments to the office where services were provided. If the amount owed to this office is less than the amount of the dental benefit payment, then the patient shall pay only the balance owed. Credits will be kept on accounts unless otherwise requested, in which case a refund can be issued within 30 days of request.

Finally, we appreciate and value the time of our patients. In recognition of fellow patients, who may have otherwise been able to attend an open appointment time slot, patients that miss multiple appointments without contacting our office may be assessed a $50 cancellation fee. I understand that I am financially responsible for all professional services rendered, and that a 25% collection fee will be assessed on all unpaid balances that are placed with our collection agency.

I understand that I am financially responsible for all professional services rendered, and that a 25% collection fee will be assessed on all unpaid balances that are placed with our collection agency.

PRINT Patient, Parent, Responsible Party SIGNATURE Date

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Limited Power of Attorney to Exercise Consent for Treatment of a Minor at Hamilton Dental Associates

I, _____
Name and Relationship

Hereby give limited power of attorney for _____
to consent to dental treatment and any medical emergency care on my behalf for my child/children

_____.
Name/Names

This limited power of attorney vests all rights and authority to legally consent to such treatment in my absence and shall be effective from the date of the document until I notify Hamilton Dental Associates of my decision to revoke such rights and authority.

Signature _____

Witness _____

Date _____