ABOUT YOUR CHILD Today's date: _____/_____/_____

Child's name: _____

Home phone#: _____

Address:_____

City:_____ State:____ Zip:_____

Birth date: _____/_____/_____ Age: _____

School: _____ Grade:_____ ☐Female ☐Male

What is your child's favorite sport? _____

Favorite toy? _____ Favorite hobby? _____

Who can we thank for referring you? _____

Father's name: _____Home ph#: _____ Cell Ph#:_____

Address:_____

City:_____ State:____ Zip:_____ Email Address _____

Mother's name: _____Home ph#: _____ Cell Ph#:_____

Address:_____

City:_____ State:____ Zip:_____ Email Address _____

PRIMARY DENTAL INSURANCE **INFORMATION**

Name of policy holder: _____Relationship:_____

Policy holder's ID/social security #: _____

Group #: _____Policy holder's birth date: _____/_____/_____

Policy holder's employer: _____

SECONDARY DENTAL INSURANCE **INFORMATION**

Name of policy holder: _____Relationship_____

Policy holder's ID/social security #: _____

Group #: _____Policy holder's birth date: _____/_____/_____

Policy holder's employer: _____

****Responsible Party/Billing Information****

Name: Last: _____MI: _____First: _____

Address: _____ City: _____ State: ____ Zip: _____

Child's Medical History

Has the child had any history of, or conditions related to, any of the following:

☐Anemia	☐Epilepsy	☐Mononucleosis
☐Arthritis	☐Fainting	☐Mumps
☐Asthma	☐Growth Problems	☐Pregnancy (teens)
☐Bladder	☐Hearing	☐Rheumatic fever
☐Bleeding disorders	☐Heart issues	☐Seizures
☐Bones/Joints	☐Hepatitis	☐Sickle cell
☐Cancer	☐HIV +/AIDS	☐Thyroid
☐Cerebral Palsy	☐Immunizations	☐Tobacco/Drug Use
☐Chicken Pox	☐Kidney	☐Tuberculosis
☐Chronic Sinusitis	☐Latex allergy	☐Other_____
☐Diabetes	☐Liver	
☐Ear Aches	☐Measles	

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... ☐Yes ☐No
If yes, please list: _____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? ☐Yes ☐No
If yes, please explain: _____
3. Is the child allergic to anything else, such as certain food..... ☐Yes ☐No
If yes, please explain: _____
4. How would you describe the child's eating habits?_____
5. Has the child ever had a serious illness? ..... ☐Yes ☐No
If yes, when: _____ Please describe: _____
6. Has the child ever been hospitalized? ..... ☐Yes ☐No
If yes why?_____
7. Does the child have a history of any other illnesses? ..... ☐Yes ☐No
If yes, please list: _____
8. Does the child have any inherited problems?..... ☐Yes ☐No
9. Does the child have any speech difficulties?..... ☐Yes ☐No
10. Has the child ever had a blood transfusion?.....☐Yes ☐No
11. Is the child physically, mentally, or emotionally impaired?.....☐Yes ☐No
12. Does the child experience excessive bleeding when cut? ..... ☐Yes ☐No
13. Is the child currently being treated for any illnesses? .....☐Yes ☐No
14. Is this the child's first visit to a dentist? ..... ☐Yes ☐No
If not the first visit, what was the date of the last dentist visit? Date:_____
15. Has the child had any problem with dental treatment in the past?..... ☐Yes ☐No
16. Has the child ever had dental radiographs (x-rays) ..... ☐Yes ☐No
17. Has the child ever suffered any injuries to the mouth, head or teeth? ..... ☐Yes ☐No
18. Has the child had any problems with the eruption or shedding of teeth? .....☐Yes ☐No
19. How much and how often does your child drink juices or soda pop? _____

20. Does/did your child suck their thumb..... ☐Yes ☐No

If so, how often? _____

21. Does/did your child use a pacifier? ..... ☐Yes ☐No

If so, how often? _____

22. Has the child ever suffered any injuries to the mouth, head or teeth? ..... ☐Yes ☐No

23. Has the child had any problems with the eruption or shedding of teeth? .... ☐Yes ☐No

24. What type of water does your child drink?

☐City water ☐Well water ☐Bottled water ☐Filtered water

25. Does the child take fluoride supplements? ..... ☐Yes ☐No

26. Is fluoride toothpaste used? ..... ☐Yes ☐No

27. How many times are the child's teeth brushed per day? _____

When are the teeth brushed?_____

28. Does the child suck his/her thumb, fingers or pacifier?..... ☐Yes ☐No

Is there any other information you would like us to know?

_____

_____

Please list the name and phone number of the child's physician:

Name of Physician _____Phone #_____

Name of preferred pharmacy: _____Phone#_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____Date:____/___/___

Appointment Policy for Modern Dentistry of New England

You are very important to us. Our team is committed to your wellbeing. We feel that working together as a team, you will receive the dental care and treatment that you deserve. Our office values your time, and our goal is to provide all of our patients with quality dental treatment in a timely manner. We make every effort to confirm scheduled appointments through postcard reminder, phone calls, text messages and emails. Failure to show for a scheduled appointment, late arrivals and last minute cancellations can be costly and unfair to other patients. Our appointment policy enables us to better utilize available appointment time for all of our patients who are in need of dental treatment.

We respect out guests' time and we make every effort to remain on schedule. Well planned appointments usually mean fewer trips to our office, resulting in less time lost from work or school. We are able to accomplish more treatment is less time at no additional cost. **It is very important that our guest understand that time is especially reserved for him/her and that appointments should be made only when they can definitely be kept.** We understand that *emergencies* arise that may make it necessary for you to reschedule an appointment. In order to be respectful of the dental needs of other patients, please be courteous and call our office if you are unable to show up for an appointment. This will allow us to reallocate your appointment time to another patient in need of treatment. **We do require 48 hours' notice, so that time reserved for you can be utilized by another patient. There is a 25.00 charge if we do not receive this courtesy or if you fail to show for an appointment.** To cancel an appointment, please call our office at 860-582-4485 during regular business hours (8:00am – 5:00pm).

For any appointment made that is over 90 minutes long our office requires a 100.00 deposit that will be applied toward payment of your dental treatment.

I, _____have read and understand the above Statement.

_____ _____

Parent or guardian signature Date

Modern Dentistry of New England Financial Policy /Agreement

We are committed to providing you with the highest quality of dental care utilizing only the best materials and technology available. In our efforts to do so, we have formulated the following financial policy. We value our patients and have worked hard to provide several options to meet your needs.

DENTAL INSURANCE

Modern Dentistry of New England is happy to partner with our patients who are covered by dental insurance by billing the insurance for you. However, it is your responsibility to inform us when your policy changes so we can bill the correct carrier. We ask that **YOU read your policy thoroughly** so that you are fully aware of the benefits provided and the limitations imposed. Please call your insurance company if you have any questions concerning your plan. Please understand that our responsibility is to provide you with **Superior Dental Care** and the treatment that best meets your needs.

It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. Estimated patient portions are due at time of service. We do our best to **estimate** your patient portion prior to your appointment. These estimates are based on the outline given by your insurance plan. Please note that these are **estimates only**. As stated by all insurances companies, there is not a guarantee of payment until the actual claim is processed. Due to policy differences and clauses you may owe more than we **estimate**. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier. If your insurance company pays more than the estimate we will issue a prompt refund.

*Outstanding insurance claims over 90 days, become the patient's responsibility. All incurred charges are ultimately the responsibility of the patient.

We are unable to carry "patient" balances over 90 days in the office. . Therefore, all overdue balances of 90 days or more are sent out of the office for collection. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care

Therefore, all overdue balances of 90 days or more are sent out of the office for collection.

PAYMENT OPTIONS:

We are pleased to offer 3 payment options for our patients:

1. We gladly accept Cash, Check (25.00 return check fee) Visa, MasterCard and American Express for your convenience.
2. Care Credit – A special No interest financing option is provided by our Doctors.
3. Limited in house financing on certain types of treatment: ½ at start of treatment with balance due at completion.

All Estimated Patient portions are due at time of service.

I have read, understand and agree to adhere to the financial policies outlined above.

Parent or guardian Signature: _____ Date:___/____/_____

Notice of Privacy Practices

Sherif Gabr D.D.S – DBA Modern Dentistry of New England

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose such information.

Without specific authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Unless you request otherwise, we may use or disclose your health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and leaving messages at your home or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights:

• The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree, we must abide by it.

• The right to request to receive confidential communications of protected health information by alternative means or at alternative locations.

• The right to access, inspect and copy your protected health information.

• The right to request an amendment to your protected health information.

• The right to receive an accounting of disclosures of protected health information, outside of treatment, payment and health care operations.

• The right to obtain a paper copy of this agreement upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have the right to file a formal complaint with us or with the Department of health & Human Services, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, please contact:

The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue S.W., Washington D.C. 20201, (877) 696-6775

For more information about our Privacy Practices, please contact:

Modern Dentistry of New England 225 N. Main St. Bristol CT 06010 (860)582-4485

***This page is for your records.**

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Modern Dentistry of New England's Notice of Privacy Practices. I acknowledge that I have had the full opportunity to read the Notice of Privacy Practices.

(*Please note: you may refuse to sign this acknowledgment.)

Patient Name: _____ Date: ____/____/_____

Patient Signature: _____

**HIPAA requires health care providers to protect the privacy of your health information. However, if you don't object, a health care provider or health plan may share relevant information with family members or friends involved in your health care or payment for your health care.

I,_____ give Modern Dentistry of New England permission to speak to:

Name: _____

Relationship to patient:_____

Patient Signature: _____

***If* patient is under 18**, *Patient's Parent or Guardian/ Relationship to patient*

Signature: _____ Date: _____ /_____/_____

Relationship to patient: _____

FOR OFFICE USE ONLY

Where Responsible Party/Parent/ Legal Guardian Does NOT Sign.

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

- ___ Individual refused to sign
- ___Communication barriers prohibited obtaining the acknowledgment
- ___ Emergency situation prevented us from obtaining acknowledgement
- ___ Other (Please Specify) _____

Modern Dentistry Staff Signature: _____