Welcome

Dr. Kamar Baloul

Revere Pediatric Dentistry

Health History Form

Today's Date:

1. Tell Us About Your Child

Child's Name _____ (Last / First / Mi)

Nickname: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate ___/___/___ Child's Age _____

School _____ Grade _____

Child's Home # ( ) _____

Child's Home Address: _____

_____ (City / State / Zip)

2. Who may we thank for referring you to our office?

_____

3. Parent/Legal Guardian Information

Name _____ ☐ Male ☐ Female

Birthdate: ___/___/___

Employer _____

Work # ( ) _____ Ext. _____

Home # ( ) _____

Cellular Phone # ( ) _____

SS # _____ DL# _____

4. Parent/Legal Guardian Information

Name _____ ☐ Male ☐ Female

Birthdate: ___/___/___

Employer _____

Work # ( ) _____ Ext. _____

Home # ( ) _____

Cellular Phone # ( ) _____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

_____ (City / State / Zip)

Home # ( ) _____

Work # ( ) _____

Cellular # ( ) _____

Email: _____

* NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # ( ) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___

SS #/ Subscriber # _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # ( ) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___

SS #/ Subscriber # _____

9. Dental History

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

If not, how long since the last visit to the dentist?_____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits?_____

Have there been any injuries to the teeth, face or mouth?_____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking/ Biting Y N Nail Biting

Y N Nursing/ Bottle Habits Y N Thumb/ Finger Sucking/ Pacifier

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD

Y N Disabilities/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Autism

Please discuss any serious medical condition the child has had

_____

Please list all drugs the child is currently taking

_____

_____

Please list all allergies _____

_____

Child's Physician _____

Phone ( ) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA , CDC, and the ADA

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent of Guardian Date Relationship to Patient

* **Parent or Guardian must accompany the child.**

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials_____Date_____

Doctor's Comments_____

_____

_____

_____

Revere Pediatric Dentistry

FINANCIAL AGREEMENT

Payments: Payment is expected in full for each appointment as services are rendered. Payment options are cash, check, or credit card (Visa, MasterCard, Discover, and American Express.)

Dental Insurance: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement or the determination of your benefits. Some and perhaps all of the service can be defined by your insurance company as "not covered", "denied" or "over UCR." We will file your **primary** dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay your portion of the charges not covered by insurance. If your insurance company requires a referral and/or pre authorization, you are responsible for obtaining it. We will file pre-treatment estimate for recommended treatment when it is requested by you.

Missed/Late Cancelled Appointment Fee: Our office requires 24 hours notification. If you are unable to keep your scheduled appointment, a fee of $25.00 will be charged to your account. If you have three missed or late cancellations, Revere Pediatric Dentistry will end the doctor/patient relationship.

Emergency/After Hours Appointment: If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

Finance Charge: A finance charge of $5.00 will be added to your account for any balance that remains unpaid after 30 days from the date of service. This charge will be assessed monthly, until the remaining balance is paid in full.

Returned Checks: There is a fee of $25.00 on any check returned by the bank.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, finance charge, (if any) and any payment or credit applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment: We can not send statements to other persons.

Past Due Accounts: If your account is past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay the collection costs which are incurred.

Divorce: In case of divorce or separation, the parent/guardian bringing the child to the office is financially responsible. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from that parent/guardian.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions herein and the agreement will be in full force and effect.

This agreement is between Kamar M. Baloul DMD, MS (pediatric dentist), and the patient/parent/debtor named on this form.

In this agreement the words "you", "your" and "yours", means the Patient/Debtor. The word "account", means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we", "us", and "our" refer to Kamar M. Baloul, DMD,MS.

By executing this agreement, you are agreeing to pay for all services that are received.

_____ _____

Patient Name Date

_____ _____

Parent/Legal Guardian/ Responsible Party Name Parent/Legal Guardian/ Responsible Party Signature

HIPAA PRIVACY STANDARDS

Acknowledgement of Receipt of Notice of Privacy Practices

Revere Pediatric Dentistry
(Practice Name)

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

Print Name**:** _____

Signature: _____

Date: _____

You May Refuse To Sign This Acknowledgement of Receipt

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.

Communication barriers prohibited obtaining the acknowledgement.

An emergency situation prevented us from obtaining acknowledgement.

Other :(Please specify) _____

_____

_____