Welcome

Dr. Kamar Baloul

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.

By initialing this box [ ] I consent to Revere Pediatric Dentistry to use my cell phone # ______________ to call and or text regarding appointments.

____
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______________

____

____

____

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) ____

____

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REVERE PEDIATRIC DENTISTRY
COVID-19 PANDEMIC DENTAL TREATMENT RELEASE FORM

PATIENT NAME: ___________________________ DATE OF BIRTH: ________________________

I, ________________________________, the parent/legal guardian of ________________________
(Patient's Name)

I and the patient knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptom and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray. The ultra-fine nature of the spray can linger in the air of minutes to sometimes hours, which can transmit the Covid-19 virus. I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. ___________ (Initial)

I understand that the CDC and MA DPH recommends social distancing of at least 3 feet between individuals and that such distancing is not possible when dentistry services are being performed. ____________ (Initial)

I confirm that neither I nor the Patient have any of the symptoms listed below, and have not had those symptoms in the past 10 days:

Fever
Dry Cough
Sore Throat
Shortness of Breath
Loss of Taste or Smell
Runny Nose

____________ (Initial)

I confirm that neither I nor the Patient have tested positive for Covid-19 or been in close contact with any person who tested positive for Covid-19 in the past 10 days. _____________ (Initial)

By my signature below, I acknowledge that I have read and understand the contents of this form or that this form has been fully explained to me in a language that I understand. I have accurately completed this form. On behalf of myself and the Patient, I hereby agree to release and hold harmless Revere Pediatric Dentistry, all employees and staff including dentists, for any risks, injury or harm of any kind resulting from Covid -19 exposure.

Parent/Guardian Signature: _________________________________ Date: ___________________

Parent/Guardian Printed: ___________________________________ Date: ___________________

PATIENT NAME/DOB: ____

PATIENT ADDRESS: ____

PARENT/LEGAL GUARDIAN EMAIL ADDRESS:____

Revere Pediatric Dentistry offers patients the opportunity to communicate with our organization and Providers by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

- E-mail can be circulated, intercepted, altered, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and be received by both intended and unintended recipients.
- E-mail senders can misaddress email.
- E-mails are archived, stored and inspected through computer system audits.
- E-mails can be used to introduce virus into computer systems
- E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL

We will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by our organization. We will not use e-mail communication for matters that may be unlawful or contain PHI or sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, sexually transmitted diseases, and issues of abuse, developmental disability, or substance abuse.

INSTRUCTIONS: To communicate by e-mail, we will request that the patient shall:

- Limit or avoid use of his/her employer's computer.
- Keep the e-mail concise, do not use for sensitive information regarding STD's substance abuse, mental health or HIV/AIDS.
- Inform us of any changes in his/her e-mail address.
- Include specific category in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear, specific and contains relevant information before sending to our organization.
- Restricted communications from the patient must be provided if applicable.
- Withdraw e-mail consent at anytime by e-mail or written communication to our organization or Provider.
- Email will not be used for urgent or emergency situations.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT EMAIL USE

I acknowledge that I have read and fully understand this e-mail consent form. I understand the risks associated with the communication of e-mail between the organization and my Provider, and consent to the conditions outlined above. In addition, I agree to the instructions outlined as described, as well as any other instructions that the organization may impose to communicate with its patients by e-mail. Any questions I may have had were answered.

PARENT/LEGAL GUARDIAN SIGNATURE: ______________________________________Date: _________

Witness Signature: ____Date: _________