Eric Maser D.M.D. 30 Orchard Street, Dover, New Jersey 07801

New Patient Registration – Child

PATIENT

Last Name: _____ First Name: _____ MI: _____ DOB**:** _____

Street: _____ Apt: _____ City: _____ ST: ____ ZIP: _____

We confirm appointments electronically by email. Please provide your email so we may remind you of scheduled appointments.

Email _____ @ _____

PARENT/GUARDIAN

Last Name: _____ First Name: _____ MI: _____ DOB**:** _____

Street: _____ Apt: ____ City: _____ ST: ____ ZIP:_____ SS#: _____

Home : _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ ST: _____ ZIP: _____

PRIMARY Dental Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____ DOB: _____

Group# _____ SS# _____

ID# _____

SECONDARY Dental Insurance: _____

Subscriber Name: _____

Relationship to Patient: _____ DOB: _____

Group# _____ SS# _____

ID# _____

Financial Policy

As the parent/guardian of this patient, you are responsible for all charges incurred for any treatment rendered regardless of insurance coverage. Payment in full is expected at time of treatment unless prior arrangements have been made. We will file claims to your insurance on your behalf, but any amount not covered by your insurance is your responsibility and payable immediately. If we have received a predetermination of eligibility from your insurance provider, any deductible and/or charges not covered by your insurance and deemed payable by you are expected at the time of your appointment.

We accept payment in cash, check or credit card. Checks returned for insufficient funds will result in a $35.00 returned check fee.

We require 24 hours notice of cancellation for all appointments. We reserve the right to charge a missed appointment fee of $50.00 for the time that was scheduled for you.

Any outstanding balance is due within 30 days of billing. Accounts more than 90 days past due are considered delinquent and will be sent to a collection agencyy. Any account sent to collection will incur a charge equal to 20% of the unpaid balance, which will be added to your account.

Thank you for your cooperation in understanding our financial policy. If you have any questions, please feel free to ask us. We will be happy to help you in any way that we can.

I have read and understand the above financial policy and agree to abide by its terms.

Parent/Guardian

Signature: _____ **Date:** _____

Pediatric Patient Health History

Child's Name: _____ Date of Birth: _____

Parent/Guardian name: _____ Home Phone: _____

Address: _____ Cell Phone: _____ _____

We prefer that you confirm appointments electronically. Please provide your email so we may send appointment reminders.
Email _____ @ _____

PEDIATRIC DENTAL HISTORY

Check (√) all that apply for your child:

☐ head injury ☐ mouth injury ☐ tooth injury ☐ nail biting
☐ thumb sucking ☐ mouth breathing ☐ pain
☐ negative past experience with a dentist or doctor
☐ other *(please explain)* : _____

Does your child brush daily? ☐ Yes ☐ No Is dental floss used? ☐ Yes ☐ No
Do you assist with brushing? ☐ Yes ☐ No Are disclosing tablets used? ☐ Yes ☐ No

How does your child receive fluoride? ☐ water supply ☐ tablets ☐ toothpaste ☐ vitamins ☐ dentist
☐ none ☐ other: _____

New Patients Only

Name of former dentist: _____ Date of last dental exam: _____

Address: _____ Date of last dental x-rays: _____

PEDIATRIC MEDICAL HISTORY

Pediatrician's Name: _____ Date of last visit: _____

Has your child been immunized? ☐ Yes ☐ No Have your child ever had any serious illnesses or operations? ☐ No ☐ Yes
(please explain below):

_____

Check (☆) all that apply:

☐ alcohol abuse ☐ anemia ☐ hemophilia ☐ Other:
☐ bleeding disorder ☐ asthma ☐ herpes _____
☐ drug abuse ☐ coughing up blood ☐ kidney disease _____
☐ heart murmur ☐ diabetes ☐ liver disease _____
☐ hepatitis ☐ epilepsy / seizures ☐ scarlet or rheumatic fever _____
☐ HIV/AIDS ☐ fainting ☐ tobacco use _____
☐ tuberculosis ☐ GERD / reflux ☐ tonsilitis

ALLERGIES

☐ *NONE*
☐ aspirin ☐ local anesthetic ☐ penicillin
☐ codeine ☐ **LATEX** ☐ sulfa
☐ other: _____
☐ other: _____

MEDICATIONS

*List **ALL** medications and supplements your child is taking.*
Use other side if necessary.

_____
_____
_____

I certify that the above information is complete and correct. I will not hold my dentist or any member of his staff responsible for any action they take or do not take because of errors or omissions I may have made on this form.

Patient signature: _____ Date: _____

STAFF USE ONLY

☐ **LATEX ALLERGY** ☐ see med list Hx taken by: _____ ☐ Dentrix updated

Rev 4/16

Eric Maser, DMD 30 Orchard Street, Dover, NJ 07801

Notice of Privacy Practices & Authorization to Use or Disclose Personal Health Information for Insurance Claim Purposes

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is required by law to protect the privacy of your personal health information, provide this notice about our privacy practices and follow those practices described herein. Upon request, we will provide you with a copy of our full privacy policy.

USE AND DISCLOSURE OF HEALTH INFORMATION

Our practice uses only the minimum necessary personal health information for the following purposes:

- Your treatment
- To obtain payment for treatment
- For internal administrative procedures

For example, we may use your personal health information to contact another provider regarding your treatment, to contact your insurance company regarding eligibility, coverage and payment, to contact you to discuss appointments and for internal administrative matters. We may also disclose your personal health information without prior authorization from you for public health purposes, government, insurance and healthcare auditing purposes and for emergencies. We will also provide information when required to do so by law. In any other situation it is our policy to obtain your written authorization before disclosing your personal health information. You may revoke that authorization in writing at any time. This policy is subject to change at any time. If changes are made, a revised Notice of Privacy Practices will be posted and a copy will be provided to you upon request. You may request a full copy of this Notice any time.

PATIENT'S INDIVIDUAL RIGHTS

- You have the right to make a written request to review your personal health information with a staff member or to obtain a copy of your personal health information. We may charge a reasonable fee for processing your request, as provided by law.
- You have the right to request that we correct any inaccurate or incomplete information you believe to be in your health records.
- You have the right to request a list of instances where you believe we have disclosed your personal health information for reasons other than those specified above. We will provide this information within 60 days of the receipt of such request and may charge a reasonable administrative fee.
- You may request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes, except when specifically authorized by you or when required by law for legal or emergency circumstances. We will consider all such requests on a case by case basis, but are not legally required to abide by those requests.
- You have the right to access the full Privacy Policy of this practice and receive a written copy of same.

CONCERNS AND COMPLAINTS

If you believe that this practice may have violated your privacy rights, or if you disagree with any decisions we have made regarding access to or disclosure of your personal health information, please contact our Privacy Officer at the address below. You may also contact the United States Department of Health and Human Services.

Sara Hudock, Privacy Officer
30 Orchard Street
Dover, NJ 07801
973-366-0311

I have read this Notice or have had it explained to me. I understand this Notice and have had the opportunity to ask questions about any part of it that I did not understand. I hereby authorize this office and any of its employees to use or disclose my personal health information for the purpose of filing any claim for services to my health insurance company. I also authorize the dental benefits otherwise payable to me be paid directly to this office. I understand that I have the right to refuse this authorization, and that by doing so, I acknowledge that I am personally responsible for filing any insurance claims and am expected to pay in full for any services at the time they are rendered. I understand that this authorization shall remain in effect until revoked by me in writing

_____	_____	_____
Signature (patient, parent or guardian)	*Print Patient Name*	*Date*

I hereby grant my permission to this office to discuss my personal health information with the following person(s):

_____	_____	_____	_____
Print Name	*Relationship*	*Print Name*	*Relationship*

Staff Notes: ☐ Individual refused to sign ☐ No Insurance ☐ Communications barrier ☐ Other_____

Eric Maser, DMD

30 Orchard Street *Dover, NJ 07801* *973-366-0311*

Insurance Agreement

Your dental insurance coverage is a contract between you, your insurance carrier and your employer, if your coverage is obtained as a benefit of your employment. As a provider, we do not have any input or control over the coverage provided by your plan. The benefits, allowances, frequencies, deductibles and out of pocket responsibilities for your treatment are determined by your contract with your insurance carrier.

Our office collects your portion of treatment expenses at the time of treatment and we submit a claim on your behalf to your insurance. The amount we collect for your portion is based on the *general* coverage estimates for each carrier. *Please note that your individual plan may vary and that you may actually owe more or less than our estimates.* We will do our best to obtain coverage information on your behalf, however, you are responsible for knowing and understanding the details of your specific insurance contract.

Once all outstanding claims are received from your insurance, we will bill you for any amount due. In the event you have paid more than required by your insurance, we will promptly issue a refund for the credit balance on your account.

While we do our best to accurately estimate what your insurance will cover, the final decision lies with your carrier. We do not get a final determination until they have completed processing each claim. There are many procedures that are "downgraded" by insurance, such as white composite fillings and porcelain crowns. In these cases many insurance policies will only pay what they allow for amalgam fillings and steel crowns. You are responsible for the difference between the amount paid by your insurance for such downgraded procedures and the fee allowance for procedures actually completed.

By signing below, I affirm that I have read and understand the information stated above. I understand that it is my responsibility to know and understand the details of my dental insurance coverage, and that payment for all treatment is my responsibility, regardless of my insurance coverage.

_____ _____

Patient Name *(please print)* *Date*

_____

Signature *(Parent or Guardian)*