Welcome to our practice!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We look forward to working with your child and you as a team to teach good oral care habits and to help your child have a beautiful smile that will last a lifetime.

Patient Information

Todays date:_____

Child's name: _____ Preferred name: _____ Pronouns: _____

Address:_____ City: _____State:_____Zip Code: _____

Sex: ☐ M ☐ F Other:_____ Date of Birth: _____ Age: _____ Hobbies/Sports: _____

Parent/Guardian Information

Name: _____ Relation:_____ Sex:_____ Date of Birth: _____

Address:_____ City: _____State:_____Zip Code: _____

Cell phone: _____ Home phone: _____Work phone: _____

Email address: _____ How did you hear about our office: _____

Responsible Party Information (if different than parent/guardian listed above)

Name: _____ Relation:_____ Date of Birth: _____

Address:_____ City: _____State:_____Zip Code: _____

Cell phone: _____ Home phone: _____Work phone: _____

Dental Insurance Information

Subscriber Name: _____ Relation: _____ Sex:_____

Date of Birth: _____ Social Security: _____ Phone: _____

Address if different :_____ City: _____State:____ Zip: _____

Employer:_____Occupation: _____

Insurance company name: _____ Insurance company phone: _____

Subscriber ID: _____ Group Number: _____ Other numbers: _____

Secondary Dental Insurance Information

Subscriber Name: _____ Relation: _____Sex: _____

Date of Birth: _____ Social Security: _____ Phone: _____

Address if different :_____ City: _____State:____ Zip: _____

Employer:_____Occupation: _____

Insurance company name: _____ Insurance company phone: _____

Subscriber ID: _____ Group Number: _____ Other numbers: _____

Dental History

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

Former Dentist name and phone : _____ Date of last dental care: _____

How often does your child brush? _____How often does your child floss? _____

Has your child ever had a chin, mouth or throat injury? _____ Pain or tenderness in jaw joint? _____

Thumb sucking or any other oral habits?_____

Medical History

Child's Physician:_____Phone:_____ Last exam: _____

Any serious illnesses or operations? _____

Any prescriptions or supplements being used currently?_____

Drug, food or material allergies (if any): _____

Any other medical issues we should be aware of? _____

Does your child snore? ☐ Yes ☐ No ☐ Occasionally (if so, when:_____)

Has your child ever had or do they currently have any of the following:

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Artificial bones/joints
- ☐ Asthma
- ☐ Blood disease
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Congenital Heart defect
- ☐ Convulsions
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Fainting
- ☐ Food allergies
- ☐ Headaches
- ☐ Hearing impaired
- ☐ Heart murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV+ / AIDS
- ☐ Immunizations current
- ☐ Kidney or Liver issues
- ☐ Respiratory Disease
- ☐ Rheumatic / Scarlet Fever
- ☐ Sickle Cell disease
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin Rash
- ☐ Sleep Disorders
- ☐ Thyroid disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other _____
  _____

Authorization

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 that 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 that my child may need. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
I understand that the parent or guardian who accompanies the child is responsible for copayment at the time of service unless prior arrangements have been approved.

Printed name: _____ Date:_____

Signature: _____

Office Policies

Thank you for choosing Papageorgiou Dental Associates as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service possible.

Payment Policy

To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment.

Please indicate below your preferred method of payment:

_____ Cash _____ Check _____ Major Credit Card _____ Other

For patients with dental insurance:

- Dental insurance usually does not cover the total cost of your treatment.
- Based on your plan, we usually can estimate the amount of your copayment.
- Your estimated copayment is expected when treatment is performed.
- If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

*** For treatment amounts over $300, please inquire about the possibility of an extended payment plan. Our office offers 6 and 12 month interest-free plans through an outside financing company. If you are interested in this option, please inquire at the front desk. Financial arrangements must be made before treatment begins.

Acceptance Agreement: (please initial each line)

_____ I understand and agree to the above financial policy.
_____ I understand that as a parent/guardian/relative bringing a child for dental treatment, I am responsible for all fees incurred at that visit.
_____ I understand that I am responsible for all fees regardless of insurance coverage. I also understand that insurance companies make no guarantee of payment until a claim is processed even if a pretreatment estimate has been completed.
_____I understand that the copayments quoted in the office are estimated, and no certainties can be made as to their accuracy.

Cancelled or Broken Appointment Policy

We make every effort to be on time for our patients and ask that you extend the same courtesy to us.
We ask that if you cannot make your appointment with us, please call at least 48 hours in advance so that we may use that time that was reserved for you to help another patient in need of our services. In cases of inadequate notice or frequent broken appointments, we reserve the right to charge a fee based on the type of appointment that was missed.

Patient/Responsible Party:

Print name: _____

Signature: _____

Date: _____

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Papageorgiou Dental Associates
959 Worcester Street
Natick, MA 01760

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:_____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient:_____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by:_____ Date: ___/___/___