NEW PATIENT FORM - PAGE 1

COHEN FAMILY SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS

We are thrilled to welcome you and your family and look forward to working with you to maintain your child's oral health. Please fill out this form as completely as possible. If you have any questions, we will be happy to help.

Tell Us About Your Child

Child's Name _____ ☐M ☐F
Last First MI

Nickname _____ Child's Birthdate _____ Age

Address _____ City _____ State _____ Zip _____

Child's Favorite Activity/Music/TV Show/Video Game _____

_____

Does Your Child Play Sports? ☐Yes ☐No If Yes, What Sports _____

Names and ages of Siblings _____

_____

How Did you Hear About the Office? (please list name)

☐Pediatrician/Other Dentist
☐School/Church/Synagogue
☐Google ☐Yelp ☐Local ☐Newspaper ☐Other _____
☐Friend
☐Insurance Company

Parent/Guardian Information

Mother's Information

Name _____ Birth Date _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Email _____

Father's Information

Name _____ Birth Date _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Email _____

Who is accompanying the child today?

Name _____ Relationship _____

Authorized Nanny/Sitter/ Au Pair

In the event that I am unable to bring my child in for an appointment the following individuals have my permission to accompany my child and make any necessary decisions for my child's care. This includes consenting to any necessary treatment plan changes.

Name _____ Relationship _____ Contact Number _____

The legal guardian must accompany their child/children for the first appointment.

NEW PATIENT FORM - PAGE 2

COHEN FAMILY SMILES
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Insurance/Financial Information

Do you have dental insurance? ☐Yes ☐No Do you have secondary dental insurance? ☐Yes ☐No

Primary Insured _____ Subscriber Name _____ Subscriber SSN _____

Date of Birth _____ Relationship to Subscriber _____

☐Self ☐Spouse ☐Child ☐Other

Employer Name _____ Insurance Company _____

Member ID # _____ Insurance Group # _____ Insurance Phone Number _____

Secondary Insured _____ Subscriber Name _____ Subscriber SSN _____

Date of Birth _____ Relationship to Subscriber _____

☐Self ☐Spouse ☐Child ☐Other

Employer Name _____ Insurance Company _____

Member ID # _____ Insurance Group # _____ Insurance Phone Number _____

Please present your insurance card to our patient services representative to be photocopied

Dental History

Reason for Today's Visit _____

Is this your Child's first visit to the dentist? ☐Yes ☐No

If not, who was the previous dentist _____ Phone # _____

When was your child's last exam? _____ When were x-rays last taken? _____

Previous Dental Injury? _____

Does your child require pre-medication prior to dental treatment? ☐Yes ☐No

Has Your Child had a history of the following and if so when did they stop:

	Age Stopped		Age Stopped
☐Bedtime Bottle		☐Mouth Breathing	
☐Fluoride		☐Snoring	
☐Vitamins		☐Thumb Sucking	
☐Pacifier		☐Finger Sucking	
☐Breast Feeding		☐Fingernail Biting	
☐Iron Supplements		☐Sleep Apnea	
☐Teeth Grinding		☐Non-fluoridated Water	
☐Bottled Water		☐Other Habit	

NEW PATIENT FORM - PAGE 3

COHEN FAMILY SMILES
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Dental History Continued

What Kind of multivitamin does your child use, if any? ❑Chewable ❑Liquid Drops ❑Gummy ❑None

Does your child take a fluoride supplement prescribed by pediatrician or previous dentist? ❑Yes ❑No

Do you brush your child's teeth or do they brush independently? _____

Does your child use: ❑Floss/Flossers ❑Fluoride Rinse (ie ACT) ❑None
*no worries we are here to teach your child the importance of flossing when indicated

Child's Temperament: ❑Shy ❑Fearful ❑Requires Special understanding ❑Easygoing ❑Calm ❑Outgoing

How do you think your child will act during dental treatment? _____

_____

How has your child's experience with other doctors been? _____

_____

Has your child had any previous negative dental experiences, if yes please explain _____

_____

_____

_____

Please list any additional questions or concerns you may have _____

_____

_____

_____

Health History

Your Child's health is ❑Excellent ❑Fair ❑Poor

Child's Physician _____ Phone # _____ Date of last physical exam _____

Ever been hospitalized overnight? ❑Yes ❑No When? _____

Reason _____

_____

Vaccinations up to date? ❑Yes ❑No*
*Cohen Family Smiles is unable to accommodate patients who are not immunized. Our numerous patients with cancer history experience a severe immunocompromised status. Please speak with the doctor with any questions and they will be happy to speak with you.

History of Surgery? ❑Yes ❑No Type of Surgery _____

_____

Does your child have any allergies (food/medications)? ❑Yes ❑No
If yes, please list _____

_____

NEW PATIENT FORM - PAGE 4

COHEN FAMILY SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS

Health History Continued

Has your child ever had any of the following conditions?

- ❑ Artificial bones/Joints
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Arrhythmia
- ❑ Autistic Spectrum Disorder
- ❑ Abnormal Bleeding
- ❑ ADHD
- ❑ Anemia
- ❑ Blood Transfusion
- ❑ Cancer/Tumors
- ❑ Birth Defects
- ❑ Cleft Lip/Palate
- ❑ Crohn's Disease
- ❑ Congenital Heart Defect
- ❑ Cerebral Palsy
- ❑ Developmental Delay
- ❑ Diabetes
- ❑ Recurrent Ear Infections
- ❑ Hearing Loss
- ❑ Endocrine Function Issue
- ❑ Epilepsy/Seizures
- ❑ Eye/Vision Problems
- ❑ Fainting/Dizziness
- ❑ Glaucoma
- ❑ Gluten/Celiac Disease
- ❑ Glucose 6 Phos. Dehy. Def.
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ High/Low Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Disease
- ❑ Liver/ Hepatitis
- ❑ Jaw Problems
- ❑ TMJ/TMD
- ❑ Jaundice
- ❑ Leukemia
- ❑ Lung Disease
- ❑ Lymphoma
- ❑ Metabolic Disorder
- ❑ Malignant Hyperthermia (or Family History)
- ❑ Milk Sensitivity (Casein/Lactose)
- ❑ Psychiatric Issues
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Speech Issues
- ❑ Sickle Cell
- ❑ Tuberculosis
- ❑ Thyroid Function Issue
- ❑ Tonsillitis
- ❑ Ulcerative Colitis
- ❑ ODD/OCD Other not listed

Please List ALL medications and dosages your child takes:

_____

_____

_____

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence.

It is my responsibility to update the office of any changes to my child's medical status and current medications.

I am the parent, guardian or personal representative of this child. There are no court orders in effect that prohibit me from signing consent for this child. I do herby request and authorize the staff at Cohen Family Smiles to perform necessary dental services for the child named in this document, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is completed.

I understand and agree that Cohen Family Smiles will make a courtesy evaluation of emergencies via cellular phone photos, should I (the parent/guardian) request this. I agree that communication may be made via secured email conversations between the doctor and myself (parent/guardian). Cohen Family Smiles will maintain the strictest measures to protect my family's privacy.

Parent/Guardian's Signature _____ Date _____

Parent/Guardian Name Printed _____

COMMUNICATION CONSENT FORM

COHEN FAMILY SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our families review and sign this Communication Consent Form.

Cohen Family Smiles will not release confidential and/or other Protected Health Information (PHI) by home mailing, home telephone, voice mail, work telephone or cell phone without consent. When we place telephone calls and voice mail responds, we do not leave PHI if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I, _____ authorized Cohen Family Smiles to contact me and/or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify the office whenever this information changes.

Email _____ ☐ Yes ☐ No

Home Phone _____ ☐ Yes ☐ No

Work Phone _____ ☐ Yes ☐ No

Voice Mail _____ ☐ Yes ☐ No

Cell Phone _____ ☐ Yes ☐ No

Please list the name of other people authorized to receive PHI about your child's care

Parent/Guardian Signature: _____ Date: _____

A copy of this document will be provided upon request

PATIENT HIPAA AWARENESS

COHEN FAMILY SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS

With my permission, Cohen Family Smiles may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations(TPO). Please refer to the Cohen Family Smiles Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cohen Family Smiles reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer. With my permission, the office of Cohen Family Smiles may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO; such as appointment reminders, insurance items and any call pertaining to my/my child's clinical care, including laboratory results among others.

With my permission, the office of Cohen Family Smiles may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Cohen Family Smiles may email to my home or other designated location and items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Cohen Family Smiles restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Cohen Family Smiles to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient/Legal Guardian _____

Print Name of Patient/Legal Guardian _____

Date _____