WELCOME

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 preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address:

_____
APT /CONDO #

_____
CITY STATE ZIP

Email Address: _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

☐ Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Wk #: (____)_____ Ext: ___ Hm #: (____)_____

Employer: _____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: ___ Hm #: (____)_____

5 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: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

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: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

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

_____

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

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / 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

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Please describe the child's current physical health:
☐ Good ☐ Fair ☐ Poor

Has the child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If so, when? _____

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

_____

_____

Aside from items below, list all drugs/materials that the child is allergic to:

_____

_____

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

7 Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	ADD / ADHD	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Artificial Bones / Joints	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Sickle Cell Disease / Traits
Y	N	Diabetes	Y	N	Tuberculosis (TB)

Please discuss any serious medical problems that the child has had: _____

_____

_____

8 Does/did the child experience any of the following?

Y	N	Lip Sucking / Biting	Y	N	Mouth Breather
Y	N	Speech Problems	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Nursing Bottle Habits
Y	N	Thumb / Finger Sucking	Y	N	Clenching / Grinding Teeth

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

9

I understand that the information that 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 or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

Sansone Family Dental Practice, L.L.P.
David F. Sansone, D.D.S.
Thomas R. Sansone, D.D.S.
4343 Dewey Avenue
Rochester, NY 14616
585-663-1390

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. The following is a statement of our Financial Policy which we ask you to read carefully and sign prior to treatment.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company.
It is our policy to charge our patients and their insurers in a fair and consistent manner. Our fees are set at usual and customary rates for this area.

All insurance information including changes and updates need to be provided to us at the time of service.

Payment in full is due at the time services are rendered. We will submit all claims to your insurance company electronically to expedite their direct reimbursement to you. Please note some, and perhaps all, of the services provided may be non-covered under your insurance plan.

If you have more than one dental insurance policy, upon receipt of payment from primary insurance carrier, please send the explanation of benefits to us and we will gladly submit to your secondary insurance carrier for you.

PAYMENTS

We accept cash, checks, American Express, Discover, Mastercard, and Visa. We also accept Care Credit. Should you make a payment by check, and it is returned unpaid, a fee of $50.00 will be charged to your account.

BROKEN APPOINTMENTS

There will be a fee based on visit type for broken appointments or cancellations not made 24 hours in advance of the appointment.

In the event that Sansone Family Dental Practice, L.L.P. pursues civil remedies against me for the collection of my financial obligations for services rendered, I hereby agree to be responsible for reasonable collection and/or attorney fees and disbursements incurred by Sansone Family Dental Practice, L.L.P.

I have read this Financial Policy and understand and agree to be personally and fully responsible for payment.

PATIENT NAME_____

PATIENT SIGNATURE_____ **DATE**_____

(Legal Guardian if under 18 years of age)

SANSONE FAMILY DENTAL PRACTICE, L.L.P.
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David F. Sansone, D.D.S.
Thomas R. Sansone, D.D.S.
4343 Dewey Avenue
Rochester, NY 14616
(716) 663-1390

Family Dentistry for the Quality Conscious

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962/25950 © MAY 2002

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4343 Dewey Avenue
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Family Dentistry for the Quality Conscious

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME_____

We will use the following methods to contact you in order to conduct business relating to your dental/medical treatment, including, but not limited to, appointments, reminders, medical results, billing and/or insurance questions:

Home Phone, Work Phone, Cell Phone, Text Message, With another person, Via mail, Via email/electronically.

Please indicate below if there are any methods you **do not** want us to use.

_____

Is there a family member, friend, or person responsible for your care that you would like us to be able to communicate with regarding your treatment and/or information from this office? If so, please list below:

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Signature_____Date_____
or
Parent/Guardian Signature_____Date_____