

# GALLERY OF LITTLE SMILES

220 Ridgedale Avenue, Suite B1

Florham Park, NJ 07932

(973) 295-6700

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_ **Birth Date:** \_\_\_\_\_ **Sex:** M / F  
First Middle Last MM/DD/YYYY

**Address:** \_\_\_\_\_  
Street City State Zip

## Parent/Guardian

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

Company Address: \_\_\_\_\_  
Street City State Zip

Marital Status:  Married  Single  Separated  Divorced

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

Company Address: \_\_\_\_\_  
Street City State Zip

Marital Status:  Married  Single  Separated  Divorced

Person(s) Responsible for Account: \_\_\_\_\_

## Insurance Information

### **Primary Insurance:**

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
First Middle Last

Patient's Relationship to Insured:  Self  Spouse  Child  Other Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_  
Name Street City State Zip

Insurance Carrier: \_\_\_\_\_ ID: \_\_\_\_\_ Group #: \_\_\_\_\_

### **Secondary Insurance:**

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
First Middle Last

Patient's Relationship to Insured:  Self  Spouse  Child  Other Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_  
Name Street City State Zip

Insurance Carrier: \_\_\_\_\_ ID: \_\_\_\_\_ Group #: \_\_\_\_\_

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Who may we thank for referring you to our practice?

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Patient  Friend  Doctor  Office  Website  School  Ad: \_\_\_\_\_  OTHER: \_\_\_\_\_

## **Dental History**

Is this your child's first trip to the dentist?  YES  NO

If NO, When was your child's last dental visit? \_\_\_\_\_

Last Dentist: \_\_\_\_\_

Name

Address

Reason for changing dentists: \_\_\_\_\_

Please tell us why you are here (*routine visit, emergency, other concerns*): \_\_\_\_\_

Has your child ever received dental treatment other than a cleaning before?  YES  NO

If YES, how did your child behave for dental treatment? \_\_\_\_\_

## **Medical History**

Pediatrician: \_\_\_\_\_

Name

Address

Phone

Does your child take/use any **prescription medication** or **prescription vitamins**?  YES  NO

If YES, please specify name and dosage: \_\_\_\_\_

Does your child have any allergies (*medication, food, seasonal, etc.*)?  YES  NO

If YES, please specify: \_\_\_\_\_

Have you ever been told that your child has a heart murmur or other heart condition?  YES  NO

If YES, does your child require antibiotic premedication before dental visit?  YES  NO

Please specify the heart condition: \_\_\_\_\_

Please check any previous or existing condition that applies to your child:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADHD              | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Possibility of Pregnancy |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Endocrine/Hormone Problems | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Prematurity/Birth Issues |
| <input type="checkbox"/> Autism            | <input type="checkbox"/> Gastrointestinal Problems  | <input type="checkbox"/> Kidney Disorder            | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Murmur/Defects       | <input type="checkbox"/> Learning/Speech Issues     | <input type="checkbox"/> Sickle Cell Disease      |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Liver Disorder             | <input type="checkbox"/> Urinary Tract Disorder   |
| <input type="checkbox"/> Cancer/Tumors     | <input type="checkbox"/> History of Surgery         | <input type="checkbox"/> Neurologic/Behavior Issues | <input type="checkbox"/> OTHER: _____             |

Please describe any medical, emotional, or behavioral condition that your child has or is suspected of having (*please be specific*): \_\_\_\_\_

*To the best of my knowledge, the information above pertaining to my child is correct and accurate. I will promptly inform the doctors of any changes in my child's health.*

Signature of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

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**PERMISSION TO TREAT**

I, \_\_\_\_\_, give my permission for Dr. Dennis Lam and his staff to treat my child, \_\_\_\_\_, for all dental treatment he/she may need. If, during a treatment visit, minor changes to treatment are found to be necessary, Dr. Lam has my permission to make these changes accordingly and complete the treatment. In the event of an unforeseen emergency, Dr. Lam has my permission to take any and all necessary steps to ensure the safety and well being of my child.

I acknowledge that I have reviewed the office's ***Policy For Treatment of Minor Children***. I understand and agree to its terms.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have reviewed the office's ***Policy For Parental Presence In The Treatment Area***. I understand and agree to its terms.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the reasonable time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**I have read the above conditions of treatment and payment and agree to their content.**

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of guarantor of payment/responsible party

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**Authorization to Release Dental Information**

I hereby authorize Gallery of Smiles or Gallery of Little Smiles to release any and all dental information to process my insurance claim.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Assignment of Benefits**

I hereby assign all dental benefits to which I am entitled to Gallery of Smiles or Gallery of Little Smiles. I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to Gallery of Smiles or Gallery of Little Smiles. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Appointment Cancellation Policy**

Your time, and the time of all other patients of the practice is important.

We take your appointment very seriously and try very hard to see each patient on time. We also make every effort to limit the length of your appointment to the time allocated so that you may make any other scheduled appointments that you may have later in the day.

In order to successfully respect your scheduling needs, we ask that you also respect the scheduling needs of others. We require a minimum 24 hours notice in order to reschedule your appointment.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be subject to a \$50 charge per missed appointment.

Thank you for your understanding and cooperation.

***By signing below, you acknowledge that you understand and agree to the above policy.***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_