Rishi Verma, DDS (NJ Spec #6022)
120 Craig Road, Suite 3
Manalapan, NJ 07726

Star Pediatric Dentistry

Phone: 732-303-STAR (7827)
Fax: 732-303-7878
drv@starpediatricdentistry.com
www.starpediatricdentistry.com

Child Health and Dental History Form

Child's Name Last First Middle	Nickname/Preferred Name	Birthday / /
Address: Street City State Zip		Gender: Male Female

Parent Info (please circle): Mother Father Guardian Foster	Parent Info (please circle): Mother Father Guardian Foster
Name: ___ Home Phone: ___ Cell Phone: ___ Work Phone: ___ Email: ___ Email appointment confirmations? Yes No	Name: ___ Home Phone: ___ Cell Phone: ___ Work Phone: ___ Email: ___ Email appointment confirmations? Yes No

How Did you Hear about us? Please write the name below:

Family Friend ___ Doctor ___ Other ___
Website ___ Advertisement ___

Pediatrician: ___ Phone: ___

Alternate Physician/Specialist: ___ Phone: ___

Please check if your child has had a history of, or currently has any condition related to any of the health conditions listed below:

- ☆ Accidents or severe infections
- ☆ Allergies (seasonal)
- ☆ Anemia or Blood Disorders
- ☆ Arthritis
- ☆ Asthma or Lung Problems
- ☆ Autism or Autistic Spectrum
- ☆ Bladder or Kidney Problems
- ☆ Bone Disorders
- ☆ Bleeding Problems
- ☆ Blood Transfusions
- ☆ Cancer (Malignancies)
- ☆ Cerebral Palsy
- ☆ Convulsions, seizures, or epilepsy
- ☆ Developmental Disabilities
- ☆ Diabetes
- ☆ Ear aches/infections
- ☆ Enlarged Tonsils
- ☆ Headaches
- ☆ Heart Murmur
- ☆ Hepatitis/Liver Disorders
- ☆ HIV+/AIDS
- ☆ Hyperactivity/ADHD/ADD
- ☆ Latex Allergy
- ☆ Measles
- ☆ Mononucleosis
- ☆ Mumps
- ☆ Pregnancy (Teens)
- ☆ Rheumatic Fever
- ☆ Sickle Cell
- ☆ Snoring
- ☆ Speech Issues
- ☆ Skin Issues
- ☆ STD
- ☆ Thyroid/Endocrine Issues
- ☆ Tobacco/Drug Use
- ☆ Tuberculosis
- ☆ Vision Disorders
- ☆ Other ___

Health History

YES NO

☆ ☆ 1). Is your child taking any medications (prescription, over-the-counter, or vitamins)?
If yes, please list all: ___

☆ ☆ 2). Is your child allergic to any of the following (if yes, please check and list below):
Foods? ___
Medications? ___
Metals? ___
Latex? ___

☆ ☆ 3). Has your child ever been hospitalized or had any type of surgery?
If yes, please explain: ___

☆ ☆ 4). Has your child ever had any type of sedation or general anesthesia?
If yes, please explain: ___
Any complications? ___

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YES NO

☆ ☆ 5). Does your child have any developmental, mental, or physical impairments?
If yes, please explain: ______________________________
☆ ☆ 6). Has your child had any excessive bleeding when cut or injured?
☆ ☆ 7). Does your child require antibiotics for dental treatment due to a heart condition, prosthesis, shunt, organ transplant, or other medical reason?
If yes, please explain: ______________________________
☆ ☆ 8). Does your child have any genetic or inherited disorders?
If yes, please explain: ______________________________
☆ ☆ 9). Is your child being treated for any other illnesses not mentioned on this form?
If yes, please explain: ______________________________

Dental History

YES NO

☆ ☆ 1). Is this your child's first dental visit? If not, when was the last time? ______________
☆ ☆ 2). Has your child ever had an unpleasant experience at a previous dentist?
If yes, please explain: ______________________________
☆ ☆ 3). Has your child ever injured their mouth, teeth, or head?
If yes, please explain: ______________________________
4). What type of water does your child drink most frequently?
☆ City
☆ Bottled --> What brand? ______________
☆ Filtered
☆ Well
☆ ☆ 5). Does your child take fluoride supplements?
If yes, please explain: ______________________________
☆ ☆ 6). Does your child use fluoridated toothpaste?
☆ ☆ 7). Do you brush your child's teeth? How many times per day? ________ When? ______________
☆ ☆ 8). Do you supervise or assist your child with brushing?
☆ ☆ 9). Does your child snack frequently between meals?
10). How much juice does your child drink daily?
☆ None
☆ 4-6 oz (one cup)
☆ 6-12 oz (two cups)
☆ more than 12 oz
☆ ☆ 11). Does your child participate in any sports or other activities
If yes, please explain: ______________________________
☆ ☆ 12). Has your child complained of any dental-related pain recently?
If yes, please explain: ______________________________
☆ ☆ 13). Do you have any other dental concerns or comments you wish addressed?
If yes, please explain: ______________________________

Habit History

Please let us know about past and current feeding and childhood habits

	Past	Current	Not Applicable	Age When Stopped
Breast Feeding	☆	☆	☆	
Baby Bottle Use	☆	☆	☆	
Contents: ____________				
Sippy Cup use	☆	☆	☆	
Contents: ____________				
Thumb/Finger Sucking	☆	☆	☆	
Pacifier Use	☆	☆	☆	
Teeth Grinding/Clenching	☆	☆	☆	

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Dental Insurance Information

Primary:
Insurance Company Name: ________________________ Group #: ___________ Identification #: __________________
Address: ____ Phone: __________________________________
Policy Owner's Name: ________________________________ DOB: _________________ SSN: _______________________
Relationship to Child: ________________________________ Employer: _____________________________________

Secondary (if applicable):
Insurance Company Name: ________________________ Group #: ___________ Identification #: __________________
Address: ____ Phone: __________________________________
Policy Owner's Name: ________________________________ DOB: _________________ SSN: _______________________
Relationship to Child: ________________________________ Employer: _____________________________________

I certify that, as this child's parent/legal guardian, all of the information I have provided in this form has been completed to the best of my knowledge. I understand that misrepresenting or withholding medical and dental information can be harmful to my child during dental treatment.

____________________________________	____________________________	__________
Parent/Legal Guardian Signature	**Print Name**	**Date**

For Office Use Only

____________________________________	____________________________	__________
Dentist's Signature	**Print Name**	**Date**

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Office Policies

At Star Pediatric Dentistry, customer service is our top priority. It helps us to make sure that we are doing the very best for you and your family. In an effort to create an environment that allows us to be our very best, we have established office policies that we would like you to review. If you have any questions, please do not hesitate to ask us.

Late Arrivals: We ask that you arrive at least 15 minutes prior to your appointment time in order to answer any questions you may have, take care of any insurance or payment issues that may arise, and allow adequate time to care for your child. We always strive to minimize wait times for all patients. Therefore, in order to avoid compromising your child's care, and in fairness to other patients who have arrived on time, late patients may be rescheduled if there is insufficient time to care for your child. We will try to accommodate late arrivals as time permits, but those patients who are on time will be seen first.

No Show Policy/Late Cancellations: We exclusively reserve time to care for your child, and we expect patients to be present at their appointment time. To avoid a charge for missed or late cancelled appointments, we request 48-hour notice. This fee must be paid before scheduling another appointment. We understand last minute issues may arise, and offer leniency in some cases, but repeatedly missed or cancelled appointments unfairly use time that may be offered to another child who requires dental treatment. After two "No Show" appointments, you may be subject to dismissal from our practice.

Photos/Videos: We understand that a child's first dental visit is an important milestone in your child's life. We ask that you inform us first, so that we may ensure that our staff do not appear in any recordings or pictures without their consent. Also, we ask that you refrain from recording or taking procedures once procedures have started and during the course of treatment.

Financing: We are committed to providing high-quality, affordable dental care for your child, and we offer a variety of payment options.

Patients Without Dental Insurance: For patients without dental insurance, payment is due the same day services are rendered, regardless of who accompanies the child to his or her appointment. For your convenience, we accept cash, checks, Visa, MasterCard, American Express and Discover credit cards. We also offer low/no-interest financing through CareCredit.

In-Network Insurance Patients: We are a preferred provider for many major insurance dental plans. If we are an in-network provider for your policy, we will file your claim as a courtesy and will accept estimates of benefit payments from these insurance companies. Your portion of co-payment and/or co-insurance is due at the time of service. **Please keep in mind that this is only an estimate of what your insurance will cover for you.** IF there is any difference after your insurance pays, we will contact you to make the necessary proper adjustments.

Out-of Network Insurance Patients: If we are out-of-network for your insurance, please check for any out-of-network benefits and we will file your claim for you as a courtesy. Although we can estimate what your insurance company will pay, there is no guarantee of reimbursement. Therefore, we require payment in full on the day of service.

It is important to understand that ***your insurance is a contract between you, your employer, and the insurance company***, not our office. No matter what your insurance status may be, please keep in mind that, ultimately, you are responsible for timely payment on your account. If your insurance company has not paid your claim in full within 30 days, you will be notified so that you can discuss the matter with your insurance company. If the claim is not paid within 45 days, the balance and all follow-up with the insurance company becomes your responsibility and all remaining balances will be charged to your credit on file after we have informed out of the payment required.

Please call our office at (732) 303-STAR for more information, and let us know if you have any questions or concerns regarding our office policies. We value the trust that you have placed in us for your child's dental care. Welcome to the Star Pediatric Dental Family!

I have read, understand, and agree to abide by Star Pediatric Dentistry's Office Policies:

Print Name: ______________________________________ Relationship: ___________________________

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Signature: ______________________________________ Date: ________________________________

Credit Card: Visa/MC/Amex/Disc #: ____ Exp: ____________