Manalapan Office
120 CRAIG ROAD, SUITE 3,
MANALAPAN, NJ 07726
(732) 303-7827

Point Pleasant Office
3824 RIVER ROAD
POINT PLEASANT, NJ 08742
(732) 202-7114

Child Health and Dental History Form

Child's Name: Last First	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: ______	Name: ______
DOB: ______	DOB: ______
Home Phone: ______	Home Phone: ______
Cell Phone: ______	Cell Phone: ______
SSN: ______	SSN: ______
Email: ______	Email: ______
Email appointment confirmations? Yes No	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). Does your child have any allergies? ______

☆ ☆ 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? ______

☆ ☆ 5). Does your child have any developmental, mental, or physical impairment?
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: ______

☆ ☆ 10). Vaccinations up-to-date?
If no, please explain: ______

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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?

Bottled Filtered City Well

☆ ☆ 5). Does your child take fluoride supplements?

☆ ☆ 6). Does your child use fluoridated toothpaste?

7). How often are your child's teeth brushed? _________ Times of day? ☆ AM ☆ PM ☆ Mid-day

8). Brushing is: ☆ Done by an adult ☆ Supervised ☆ Child brushes alone

9). How often are your child's teeth flossed? _________ Times of day? ☆ AM ☆ PM ☆ Mid-day

10). Flossing is: ☆ Done by an adult ☆ Supervised ☆ Child flosses alone

☆ ☆ 11). Is your child experiencing any dental related pain? ____

☆ ☆ 12). Do you have any other dental-related concerns you wish addressed?_____________________________

____

Habits

Check all that apply

☆ Grinding Teeth
☆ Thumb/Finger Sucking
☆ Pacifier Use
☆ Nail Biting
☆ Clicking or Popping Jaw
☆ Food Collection Between Teeth
☆ Bad Breath
☆ Bleeding Gums
☆ Mouth Breathing

Nutrition			
Breast Feeding:	Current	Past	Not Applicable
Baby Bottle Use:	Current	Past	Not Applicable
Sippy Cup	Current	Past	Not Applicable
Does your child take the bottle to bed?	Yes	No	
Flavor in Milk	Yes	No	
Does your child eat/drink after brushing at night?	Yes	No	
Sticky Foods (fruit snacks, gummy candies, dried fruits)	Daily	1-2x a week	
Carbohydrate-rich Snacks (cookies, crackers, chips, goldfish)	Daily	1-2x a week	
Juice Intake Daily	1 cup	Greater than 1 cup	

I certify that all of the information I have provided in this form has been completed to the best of my knowledge and that misrepresenting or withholding medical and dental information can be harmful to my child during dental treatment.

______________________________ ______________________________ ______________

Parent/Legal Guardian 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 does not appear in any recordings or pictures without their consent. Also, we ask that you refrain from recording/taking pictures once procedures have started & during the course of treatment.

Financial Policy: 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 those without dental insurance, payment is required the same day services are rendered, regardless of who accompanies that child to his or her appointment. For your convenience, we accept cash, checks, Visa, MasterCard 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 our claims 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 will be charged to your credit card on file. You are responsible for all follow-up with the insurance company directly.

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 Dentistry Family!

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

Print Name: ________________________________ Relationship: ________________________

Signature: _________________________________ Date: ____________________________

Credit Card: Visa/MC/Disc #: ______________________________ Exp: __________ CVV# ____________
(Your CC will be charged only if there is a balance on the account greater than 45 days and we have not heard from you regarding settling your balance)

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PATIENT HIPAA AWARENESS

With my permission, Dr. Rishi Verma and Star Pediatric Dentistry may use and disclose protected health information (PHI) about me or my child to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dr. Rishi Verma 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. Dr. Rishi Verma 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 Dr. Rishi Verma 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 clinical care, including laboratory results among others.

With my permission, the office of Dr. Rishi Verma may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my permission, the office of Dr. Rishi Verma may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Rishi Verma restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If it does, it is bound by this agreement.

By signing this, I am allowing Dr. Rishi Verma and Star Pediatric Dentistry to use and disclosure 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 or Legal Guardian

________________________________ __________________
Print Name of Patient or Legal Guardian Date