Dr. Jeffrey D. Singer
Specialty Permit # 5722
1001 Laurel Oak Road
Suite C-2
Voorhees, NJ 08043
Phone: (856) 783 – 3515
Fax: (856) 783 – 3517
www.abcchildrensdentist.com

PATIENT REGISTRATION

Date__________________

1. Tell Us About Your Child

Child's First Name ________________________ Middle Initial______ Last Name________________
Nickname (if any) ____________________________ Date of Birth___________ □ Male □ Female
What are your child interests/hobbies? ____
Social Security # ____________________________ Home Phone ____________________________
Home Address____
City______________________________________ State___________ ZIP_____________________
School________________________Grade_____Siblings_____________________________________

2. Mother's/Guardian's Information

Name____________________________________
Birth Date ___________Home Phone___________
Cell Phone____________ Work Phone__________
Home Address_____________________________
City_______________ State____ ZIP_________
Employer_________________________________
E-mail___________________________________

3. Father's/Guardian's Information

Name____________________________________
Birth Date __________Home Phone____________
Cell Phone___________ Work Phone____________
Home Address______________________________
City________________ State____ ZIP_________
Employer__________________________________
E-mail____________________________________

4. Who Is Accompanying the Child Today?

Name____________________________________
Relationship______________________________
Do you have legal custody of this child?
□ Yes □ No

5. Responsible Party Information

Name ____________________________________
Birth Date _________ Home Phone_____________
Cell Phone__________ Work Phone_____________
Home Address______________________________
City________________ State____ ZIP_________

6. Primary Dental Insurance

Insurance Company Name___________________
Insurance Company Address_________________
____
Insurance Company Phone #_________________
Group # (Plan, Local, or Policy #)______________
Policy Owner's Name________________________
Relationship to Patient______________________
Policy Owner's Birth Date __________________
Social Security #__________________________
Policy Owner's Employer_____________________

7. Secondary Dental Insurance

Insurance Company Name____________________
Insurance Company Address__________________
____
Insurance Company Phone #__________________
Group # (Plan, Local, or Policy #)______________
Policy Owner's Name_________________________
Relationship to Patient_______________________
Policy Owner's Birth Date____________________
Social Security #___________________________
Policy Owner's Employer______________________

How did you hear about our office? Or who may we thank for the referral? _________________
___________ ____

PATIENT MEDICAL HISTORY

Patient's Name______________________ Birth Date____________________

	YES	NO		YES	NO
Heart Murmur	□	□	Asthma	□	□
Heart Disease	□	□	Lung Disease	□	□
Cardiac, Pacemaker	□	□	Tuberculosis	□	□
High Blood Pressure	□	□	Epilepsy	□	□
Rheumatic Fever	□	□	Nervous Disorder	□	□
Prolonged Bleeding When Cut	□	□	Chemical Dependency	□	□
Blood Transfusion, Date_____________	□	□	HIV/AIDS	□	□
Cancer, Tumor	□	□	Metallic Implant	□	□
Kidney Disease	□	□	Glaucoma	□	□
Diabetes	□	□	Is the patient pregnant?	□	□
Hepatitis, Liver Disease	□	□	Bleeding Gums	□	□
Thyroid Disease	□	□	Bad Breath	□	□
Cold Sore, Fever Blister	□	□	Puberty/Growth Spurt	□	□
Drug/Food Allergy. If yes, to What medications/foods?____________ ______________________________	□	□	Latex Allergy	□	□

Is there any other health information that should be known? ____
____

Is the patient taking any medications? □ Yes □ No If yes, please list the medications and reasons: _______
____

Has the patient recently been under the care of a physician or had a serious illness or operation in the last 5 years? □ Yes □ No If Yes, please explain ____
____

Name & Phone Number of the patient's Physician: ____

Is this your child's first dental visit? □ Yes □ No

Last Dental Visit: ___________ Dentist's Name & Phone Number: ________________________________

Does the patient have a specific dental problem that needs attention? □ Yes □ No If yes, please explain:
____

Has the patient experienced any unfavorable reaction from any previous dental or medical care? □ Yes □ No
If yes, please explain: ____

I understand that the information 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** **Relationship to Patient**

CANCELLATION POLICY: Any cancelled appointments with less than 24 hours notice from the scheduled appointment time is subject to a $25.00 charge per patient. For example, if an appointment is scheduled with Dr. Singer at 9:00AM and the appointment is cancelled at 3:00PM the day before, this is defined as a "cancelled appointment". ABC CHILDREN'S DENTISTRY does not double-book appointments, therefore our office only schedules one appointment per allotted half-hour. Therefore, if there are any cancelled appointments, our office must still fill the schedule daily. Any siblings that are booked together are considered two appointments (hence, a one hour appointment). If our office schedules a set of siblings together and there is one cancellation, we will not be able to book any siblings together in the future on the same day. After the third cancelled appointment at Dr. Singer's discretion, the patient (or family) will be discharged from ABC CHILDREN'S DENTISTRY. Dr. Singer respects the valued time while he is treating his patients and in turn would appreciate for his time to be respected.

CONFIRMATION POLICY: All appointments at ABC CHILDREN'S DENTISTRY require a CONFIRMATION (phone call, email or message on the office answering machine). Our office will attempt to contact the child's parent/guardian the day prior to your scheduled appointment. If we do not reach you, we will try contacting you again before our office is closed. At this time, we require a confirmation for your appointment at (856) 783-3515. Feel free to email us at www.abcchildrensdentistcom. Please leave a message on our answering machine after business hours. You may also call us at any time to confirm your appointment.

FINANCIAL POLICY:

PATIENTS WITH INSURANCE COVERAGE: ABC Children's Dentistry obtains an insurance verification for any insurance we participate with. For participating insurances, a pre-estimate based on your insurance benefits will be provided to help you obtain the appropriate benefit from your insurance carrier. We bill your insurance carrier as a courtesy to you. However, you are responsible for the payments of the account. Any portions of the bill that are not paid by the insurance company are the responsibility of the parent/guardian. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double insurance coverage (this is possible if you and your spouse both have insurance), there still may be a portion that will be your responsibility. If you are having treatment over a period of time, payment is due when services are rendered.

PATIENTS WITHOUT INSURANCE COVERAGE: Patients without insurance coverage are required to pay for services when they are rendered.

ADDITIONAL TERMS: We accept Mastercard, Visa, Check and Cash payments. There will be a charge for any duplication of X-Rays. Depending on the X-Ray(s) in question a charge between $5.00-$25.00 will be administered. Patients are not authorized to remove the originals from the premises. Any checks that are returned are subject to a $25.00 charge. In addition, any other bank fees that are incurred are the responsibility of the parent/guardian. If there are any balances on the patient's account, no appointments will be scheduled. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of ½% per month (6% per annum). If your account is referred for collection, you will be responsible for collection costs in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take the opportunity to welcome you to ABC CHILDREN'S DENTISTRY and assure you that we will do our utmost to provide you with the best care possible.

I HAVE READ AND UNDERSTAND THE CANCELLATION, CONFIRMATION AND FINANCIAL POLICIES OF ABC CHILDREN'S DENTISTRY:

__________________________________ ____________________________

Signature of Parent or Guardian **Date**

PARENTAL RELEASE FORM

This form is intended for anyone other than the parent/guardian to bring the patient to the appointment, (For example, grandparents, aunt/uncle)

We understand that sometimes it may be difficult to get time off work to bring your child to their dental appointment. Because of this, it sometimes becomes necessary for parents to send a family member or friend with the child. Due to the fact that they are not the child's legal guardians, they need to be authorized by you to consent to dental treatment for your child.

I________________________________, hereby authorize
(Parent/Legal Guardian)

_________________________________, to bring my child
(Responsible Party)

_________________________________, to his/her dental visits.
(Child's Name)

I authorize the above responsible party to make decisions regarding treatment for my child.

I understand that sending my child with someone else does not in anyway relieve me of my financial responsibilities for treatment on that day. Also, I understand that a change in the treatment plan will also change the amount for treatment on this day and is expected at the time of service. The responsible party should be made aware of this before agreeing to bring your child. They will be responsible for payment at the time of service.

___________________________________ _______________
Signature of Parent/Legal Guardian Date

___________________________________ _______________
Witness Date

ABC Children's Dentistry
Dr. Jeffrey D. Singer, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT/PARENT/GUARDIAN GIVING CONSENT

Name: ____

Address: ____

Telephone #: __________________________________ E-mail: ___________________________________

Parent/Guardian/Guarantor's Social Security Number: ____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jeffrey D. Singer
Telephone: (856)783-3515 Fax: (856)783-3517
E-mail: abcchildrensdentistry@gmail.com
Address: 1001 Laurel Oak Rd, Suite C-2 Voorhees, NJ 08043

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:____ Date:___________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me or my child after I have revoked my Consent.

Signature:____
Date:____________________________

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