BRIDGEWATER DENTAL ASSOCIATES

David Weedon, DDS
General Dentistry

Ryan Scally, DMD
Pediatric Dentistry, NJ Spec #06161

Date: _____

Patient Information

Last Name: _____ First Name: _____ Nickname: _____

Birthdate: _____ Age: ____ Sex: M ☐ F ☐

Home Address: _____
Street City State Zip code

Who may we thank for referring you: _____

Parent/Guardian Information

Parent/Guardian 1:

Name: _____ Birthdate: _____ Phone #: _____
Home Mobile

E-mail: _____ Employer: _____ SSN: _____

Home Address: _____
Street City State Zip code

Insurance Plan Name: _____ Group #: _____ Policy #: _____

Parent/Guardian 2:

Name: _____ Birthdate: _____ Phone #: _____
Home Mobile

E-mail: _____ Employer: _____ SSN: _____

Home Address: _____
Street City State Zip code

Insurance Plan Name: _____ Group #: _____ Policy #: _____

Emergency Contact

Name: _____ Relationship: _____ Phone#: _____

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Medical History

Date of last physical exam _____

☐ **Yes** ☐ **No** Has your child ever had a health problem? _____

☐ **Yes** ☐ **No** Is your child allergic to anything? _____

☐ **Yes** ☐ **No** Is your child currently taking any medications? Please give medication, dose, and reason: _____

_____

☐ **Yes** ☐ **No** Are your child's immunizations current?

☐ **Yes** ☐ **No** Have you ever been told that your child needs to take *antibiotics before dental treatment*?

☐ **Yes** ☐ **No** Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:

_____

☐ **Yes** ☐ **No** Were there any difficulties at birth? _____

Please check if your child has been treated for any of the following:

☐ Abuse	☐ Cancer/tumors	☐ Heart murmur	☐ Rheumatic fever
☐ ADD/ADHD	☐ Cerebral palsy	☐ Hepatitis	☐ Seizures
☐ AIDS/HIV	☐ Cleft lip/palate	☐ Kidney disease	☐ Sickle cell disease/trait
☐ Anemia	☐ Congenital birth defects	☐ Liver/GI disease	☐ Significant injuries
☐ Anxiety disorder	☐ Diabetes	☐ Mental delays	☐ Snoring
☐ Arthritis	☐ Endocrine/growth	☐ Personality/social disorder	☐ Speech/hearing
☐ Asthma/breathing	☐ Eyesight	☐ Physical delays	☐ Spina bifida
☐ Autism	☐ Frequent infections	☐ Recurrent headaches	☐ Tonsil/adenoid problems
☐ Bleeding/transfusions	☐ Heart Disease	☐ Recurrent herpes/fever blisters	☐ Tuberculosis

Other: _____

If any boxes are checked, please describe further: _____

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Authorization for Treatment and Insurance

I do hereby request and authorize Bridgewater Dental Associates to examine and provide necessary dental treatment. I further request and authorize the taking of dental x-rays and photographs when needed for diagnostic and treatment purposes.

As a courtesy to you, we will file your dental insurance claim and we will also accept assignment of benefits when applicable. You will be expected to pay your estimated uncovered portion at the time of service. You must be familiar with your insurance benefits and you are responsible to inform of us of any changes to your coverage. Once the insurance company reimburses our office, if there is a balance, you will be billed for the remaining portion. If there is a credit, you will be sent a refund check. I understand that the information that I have given is correct to the best of my knowledge and authorize the use of my signature on all insurance submissions.

Patient or Legal Guardian Signature _____ Date_____

Consent for use and disclosure of health information

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 insurance processing.

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, insurance processing and disclosures we may make of your protected health information. A copy of our notice is available with 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. 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 requesting it from us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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 will decline to treat you or to continue treating you if you revoke this consent.

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 as described in the "Notice of Privacy Practices."

Patient or Legal Guardian Signature _____ Date_____