Gina M. Tanios-Rafla, DMD
646 Highway 18, Suite 114
East Brunswick, NJ 08816
(732) 238-1760

Thank you for trusting us with your child's dental care. We promise to do our best to provide your child with the finest care available. If you have any questions please do not hesitate to call us.

Patient# _____

Date _____

CHILD PATIENT INFORMATION

Name_____Birthdate_____SS#_____
Sex ☐M ☐F

PARENT/GUARDIAN ACCOMPANYING CHILD

Name_____Phone#_____Birthdate_____Are you a patient? ☐Yes ☐No
☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years
Driver's License#_____SS#_____
Home Phone_____Cell Phone_____Email_____
Address_____City_____State____Zip_____
Preferred Method of Contact (please circle all that apply) Home Phone Work Phone Cell Phone Email
Employer_____Work Phone_____
Employer Address_____City_____State____Zip_____

HOW DID YOU HEAR ABOUT US?

Please Circle: Friend Relative Internet Yellow Pages Sign Other
Name of referral source (which friend, relative, etc)_____
Name of lactation consultant_____Phone#_____

ADDITIONAL PARENT/GUARDIAN INFORMATION

Are they a patient? ☐Yes ☐No
Name_____Birthdate_____
SS#_____Work Phone_____Cell Phone_____
Employer Name_____

INSURANCE INFORMATION

Primary Dental Insurance – Who is the insured? Relationship to child ☐Parent ☐Guardian ☐Other
ID#_____Group#_____
Insurance Plan Name_____Address_____
City_____State_____ Zip_____ Phone_____
Secondary Dental Insurance – Who is the insured? Relationship to child ☐Parent ☐Guardian ☐Other
ID#_____Group#_____
Insurance Plan Name_____Address_____
City_____State_____Zip_____Phone_____

MEDICAL HISTORY

Patient Name_____Age_____Date_____

Name of Pediatrician_____ Pediatrician Phone_____

Date of last visit to Pediatrician_____Rate your child's general health ☐Poor ☐Fair ☐Good

PLEASE CHECK YES OR NO FOR THE FOLLOWING

YES	NO	Allergic reaction to:	YES	NO	
☐	☐	Aspirin, Ibuprofen, Acetaminophen	☐	☐	Hormone / Endocrine problems
☐	☐	Penicillin	☐	☐	Diabetes
☐	☐	Erythromycin	☐	☐	High cholesterol
☐	☐	Codeine	☐	☐	Stomach / Digestive problems
☐	☐	Local anesthetic	☐	☐	Ulcers
☐	☐	Latex	☐	☐	Arthritis
☐	☐	Metals (gold, stainless steel)	☐	☐	Rheumatism
☐	☐	any other medications:	☐	☐	Glaucoma
			☐	☐	Head or neck injury
☐	☐	Hospitalization for illness or injury	☐	☐	Venereal disease / STD
☐	☐	Artificial heart valve	☐	☐	Hepatitis (type)
☐	☐	Artificial joints	☐	☐	AIDS / HIV
☐	☐	Implants	☐	☐	Tumor or abnormal growth
☐	☐	Rheumatic fever	☐	☐	Cancer – if yes what kind?
☐	☐	Scarlet fever	☐	☐	Radiation therapy
☐	☐	Heart problems (murmurs, etc)	☐	☐	Chemotherapy
☐	☐	Heart disease	☐	☐	Mood disorder / Emotional problems
☐	☐	Chest pains / angina	☐	☐	Nervous disorder
☐	☐	High blood pressure	☐	☐	Psychiatric treatment
☐	☐	Stroke	☐	☐	Antidepressant medication
☐	☐	Low blood pressure	☐	☐	Alcohol or drug dependency
☐	☐	Dizziness or fainting			
☐	☐	Pacemaker	**IS YOUR CHILD:**		
☐	☐	Anemia / Bleeding disorder	☐	☐	Being treated for any illness
☐	☐	Prolonged bleeding due to a slight cut	☐	☐	Aware of a change in your health
☐	☐	Emphysema	☐	☐	Often exhausted or fatigued
☐	☐	Tuberculosis	☐	☐	A tobacco user
☐	☐	Asthma	Type_____		
☐	☐	Respiratory problems	Amount/Frequency_____		
☐	☐	Sinus problems	Do you want to quit?		
☐	☐	Hay fever, hives, skin rash	☐	☐	Considered a touchy person
☐	☐	Kidney disease	☐	☐	Often unhappy or depressed
☐	☐	Liver disease	☐	☐	Easily upset or irritated
☐	☐	Jaundice	☐	☐	FEMALE – taking birth control pills
☐	☐	Thyroid or parathyroid problems	☐	☐	FEMALE – pregnant

Please describe any current medical treatment or impending surgery that may affect your child's dental treatment_____

_____

List **ALL Medications, Vitamins, Herbal Supplements,** or **Dietary Supplements your child is currrently taking**

_____

_____

Is your child currently taking or have they previously taken any of the follwing medications ☐YES ☐NO
Coumadin/Warafin, Plavix, Fen-Phen/Redux/Pondimin, Biophosphonates(Fosamax, Boniva, Actonel,Zometa,Aredia)

PLEASE ADVISE US OF ANY CHANGES IN YOUR CHILD'S MEDICAL HISTORY OR MEDICATIONS IN THE FUTURE.

Parent/ Legal Guardian's Signature_____Doctor's Signature_____

DENTAL HISTORY

Previous Dentist_____How long ago was last visit? _____

What is your child's immediate dental concern?_____

How often does your child brush their teeth? ☐Once a day or less ☐Twice a day ☐More than twice a day

How long does your child spend brushing their teeth each time they brush? ☐Less than 2 mins ☐Two mins or longer

How often does your child floss their teeth? ☐Never ☐Rarely ☐Once a day ☐More than once a day

Do you supervise/assist your child with brushing/flossing? ☐Yes ☐No

How many sodas, sports drinks, or energy drinks does your child drink a day? ☐None ☐One ☐More #_____

YES	NO	**PLEASE CHECK YES OR NO FOR THE FOLLOWING:**
☐	☐	Is your child self conscious or concerned about the appearance of their teeth?
☐	☐	Would you like us to discuss proper brushing and flossing with your child?
☐	☐	Does your child have sensitive or sore teeth?
☐	☐	Does your child have bleeding gums?
☐	☐	Does your child have an unpleasant taste or odor in their mouth?
☐	☐	Has your child previously had orthodontic treatment (braces) or an orthodontic evaluation?
		If yes, who was the doctor? _____
		If no, have either parent or any siblings had orthodontic treatment? ☐Yes ☐No
		If yes, who was the doctor? _____
☐	☐	Does your child currently wear any type of appliance (retainer, nightguard, mouthguard, etc)?
		If yes, what type of appliance? _____
☐	☐	Does your child have jaw problems (TMJ problems)?
☐	☐	Does your child have jaw clicking or popping?
☐	☐	Does your child's jaw ever lock?
☐	☐	Does your child have difficulty opening their mouth widely?
☐	☐	Does your child have tension headaches?
☐	☐	Are your or your child aware of any clenching or grinding of their teeth?
☐	☐	Has your child had any unfavorable previous dental experiences?
		If yes, please discuss this privately with Dr. Tanios-Rafla.
☐	☐	Does your child have anxiety about dental visits?
☐	☐	Does your child have any lumps or swelling in their mouth?

YES	NO	**PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:**
☐	☐	My child goes to bed with a bottle.
☐	☐	My child uses a pacifier.
☐	☐	My child uses a sippy cup.
☐	☐	My child sucks their thumb or fingers.

Parent/Legal Guardian's Signature _____Doctor's Signature_____

Gina M. Tanios-Rafla, DMD

Laser Dentistry of New Jersey

FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, Mastercard, Discover and American Express.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.
- If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.
- We do not file claims for medical insurance.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A **$25** charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to **additional fees**. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least 48 hours in advance to avoid a missed appointment fee of up to **$50**. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your records or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Gina Tanios-Rafla, D.M.D. Without any reservations, I agree to abide by the policies outline herein.

_____ **I understand that the *LASER* fee is not a covered expense by the insurance Co.**

Form completed by:

Name_____ Signature_____

Relationship to patient if patient is a minor_____ Date_____

Reviewed by staff member_____ Date_____