harmony dental KIDS

Patients Name_____Nickname_____ Date:_____

☐ Male ☐ Female

Address:_____ _____ _____ _____

Street City state zip

Social Security #:_____ Birth Date:_____

PARENT/GUARDIAN ACCOUNT INFORMATION

Name:_____

Address: _____

Phone (Home): _____

Phone (Cell): _____

Phone (Work):_____

E-Mail: _____

Employer/Division: _____

Address: _____

Primary Dental Insurance Co.: _____

Address: _____

Membership/Policy#: _____

Social Security#: _____

Date Of Birth: _____

Relationship: _____

Name: _____

Address: _____

Phone (Home): _____

Phone (Cell): _____

Phone (Work):_____

E-Mail: _____

Employer/Division: _____

Address: _____

Secondary Dental Insurance Co.: _____

Address: _____

Membership/Policy#: _____

Social Security#: _____

Date Of Birth: _____

Relationship: _____

Person Financially Responsible: _____

PLEASE TELL US HOW YOU HEARD ABOUT US:_____

(We would like to thank them)

DENTAL HISTORY

Specific Concerns:_____

Is this your child's first dental visit? (Yes or No) _____ Were X-rays taken? Yes ❑ No ❑ Date of last X-rays _____

If No, previous dentist's name: _____ Date of last visit: _____

Do you have well or city water? _____

Any Unhappy Dental Experiences?_____

Any Oral Habits- thumb sucking, nail biting, pacifier etc.?_____

Child's Attitude towards dentistry?_____

Parent's Attitude towards dentistry?_____

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Medical/ Health History

Child's Physician _____ City _____ Tel. _____

Date of last physical examination _____ Results _____

	YES	NO
1. Is your child under the care of a physician (other than routine care) now? _____ Name of Dr. _____	❑	❑
2. Does your child take any medications or supplements? _____	❑	❑
3. Has your child ever been hospitalized? _____ _____	❑	❑
4. Has your child ever had surgery? _____ Reason: _____	❑	❑
5. Is there anything artificial placed in your child's body, such as pins, shunts, rods, etc._____	❑	❑
6. Does your child have any allergies (i.e.,penicillin, latex, nuts, etc.)? _____	❑	❑
7. Are there any physical problems? _____ _____	❑	❑
8. Are there learning difficulties? _____	❑	❑
9. Were there problems at or before birth? _____ _____	❑	❑
10. Does your child have bleeding disorders? _____ _____	❑	❑

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

❑ Anemia	❑ Diabetes	❑ Heart / Heart Murmur	❑ Malignancies
❑ Asthma	❑ Epilepsy	❑ Hepatitis	❑ Rheumatic Fever
❑ Cerebral Palsy	❑ Frequent Infections	❑ HIV	❑ Thyroid
❑ Chronic Sinus	❑ Headaches	❑ Kidney	❑ Tuberculosis
❑ Convulsions	❑ Hearing	❑ Liver	❑ Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of: _____

_____

	YES	NO
May we request release of your child's medical records for our reference? _____	❑	❑

PERMIT FOR TREATMENT UPON A MINOR

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor.

Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: _____
(signature and relationship to patient)

The Harmony Dental Group

161 EAST AVE STE 201 | NORWALK CT, 06851 | (203) 354-3193

Written Financial Policy

Thank you for choosing The Harmony Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options.

Payment is due at the time of service either in full or your out of pocket should you have insurance benefits.

Payment Options: You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

  We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care.

  - Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note: For treatment plans of $50.00 or more, a 20% deposit is required to secure each appointment.

The Harmony Dental Group requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Should your treatment be non-covered or the benefit estimate not paid in full the balance is your responsibility.

A fee is charged for patients who miss their appointment without 48-hour notice. The amount charged directly corresponds to the amount of the treatment scheduled for that appointment.

The Harmony Dental Group charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

The Harmony Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Information

Name: _____

Address _____

Telephone: _____

Section B: Purpose of Consent and Patient Approval/Signature

By signing this form, you are consenting 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 form. Our notice provides a description of the uses and disclosures we may make of your protected information. A copy of our notice is available upon request. 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. Those changes may apply to any of your protected health information that we maintain.

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

Contact Name: The Harmony Dental Group
Telephone: 203-354-3193
Fax 203-604-0199
Email: theharmonydentalgroup@gmail.com
Address: 161 East Avenue, Suite 201 Norwalk, CT06851

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice addressed to the contact name 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 health care operations.

Signature:_____Date:_____

If this consent is signed by a personal representative on behalf of the patient, print name below:

Personal Representative's Name:_____
(Please print)