East Brunswick
Pediatric Dentistry

17 Brunswick Woods Drive East Brunswick, NJ 08816
Phone: 732-238-5100, Fax: 732-238-0792
Email: ebpd17@yahoo.com

Patient Information

Patient Name:_____ Today's Date:_____
Last, First MI (Preferred Name)

Gender: _____ Social Security #:_____ Birth Date:_____

Phone (Home):_____ Cell: _____

E-mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Has the patient ever had any of the following? Please check those that apply:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Peanut Allergy
- ☐ Tree Nut Allergy
- ☐ Dairy Allergy
- ☐ Allergy _____
- ☐ Allergy _____
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disease
- ☐ Cancer
- ☐ Developmental Disability
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Tumors

OTHER:
☐ _____

Date of Last Dental Visit: _____ Reason for this visit: _____

- Has the patient ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- **Name of Primary Care Physician/Pediatrician: _____ Phone:** _____
- Has the patient been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the patient now under the care of a specialist? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the patient taking any medication? ☐ Yes ☐ No
  If yes, please list: _____

How did you find out about our office? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change in the above patient's health, I will inform this practice and doctors at the next appointment without fail.

_____ Date: _____
Signature of Patient/Parent/Legal Guardian/Personal Representative

Patient's Name:

Responsible Party Information:

Name: _____ ☐ Male ☐ Female

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ (Cell): _____ (Work): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Insurance Holder's name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip Code

Insurance Company Name: _____

ID #: _____ Group #: _____

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Child ☐ Other _____

Secondary

Insurance Holder's name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip Code

Insurance Company Name: _____

ID #: _____ Group #: _____

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Child ☐ Other _____

Consent for Services

Patients with or without dental insurance understand that all dental services provided are charged directly to the patient/parent/legal guardian/guarantor and such person is personally and financially responsible for payment of all dental services provided. The undersigned hereby certifies that the above information I have given is correct to the best of my knowledge. I will not hold Jason Nudelman, DDS, PC, East Brunswick Pediatric Dentistry (hereinafter EBPD) or any member of the staff or employee thereof responsible for any errors or omissions that I may have made in the completion of these forms. As a condition of treatment by EBPD, financial arrangements must be made in advance. All emergency dental services or any dental services performed without previous financial arrangements must be immediately paid for at the time services are rendered. The above-named patient has insurance coverage with the dental insurance company's name as indicated above and assigns directly to EBPD all insured benefits for services rendered. I hereby authorize EBPD to release all information relating to the patient's dental care to secure the payments of benefits from the insurance company and authorize use of my signature below on all insurance submissions. I understand that EBPD will assist in submitting the appropriate claim forms to the patient's insurance company and will credit any insurance payments to the patient's account. I understand that I am financially responsible for all charges whether or not said charges are paid in whole or in part by the insurance company. I authorize and assign payments of all dental benefits, otherwise payable to me, directly to EBPD. A service charge of 1.33% per month (16% per annum) on the unpaid balance will be charged on all accounts not paid within 60 days, unless previously written financial arrangements have been made and satisfied. If the patient's account is more than 60 days overdue, the account may be sent to collections. I hereby authorize EBPD to release all information relating to the patient's dental care to the collection agency in order to secure payments due. I further agree to reimburse EBPD the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fees, and legally permitted interest, that EBPD incurs in such collection efforts. I grant permission to EBPD to telephone me at home or at my work to discuss matters related to these forms. I authorize the Doctors and the Dental staff at EBPD to perform the necessary dental services my child may need including, but not limited to, the use of nitrous oxide, x-rays, prophylaxis and fluoride treatment. If it is necessary to cancel an appointment, it must be done 48 hours prior to the scheduled time of the appointment. I understand that there will be a charge of $75 dollars for a missed appointment without said 48 hours' notice. I certify that I have read and understand the above.

I, Parent/Legal Guardian of the above named patient give my permission for _____, relationship _____ to accompany the above named patient to his/her dental appointment and make any necessary medical and dental treatment decisions.

_____ _____ _____
Signature: Patient/Parent/Legal Guardian/Personal Representative/Guarantor Relationship to Patient Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA)
http://www.hhs.gov/ocr/hipaa/finalreg.html

PATIENT/PARENT(S) / LEGAL GUARDIAN(S) / PERSONAL REPRESENTATIVE GIVING CONSENT

Patient's Name: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this consent form, you are consenting to Jason Nudelman, DDS, PC, East Brunswick Pediatric Dentistry (hereinafter EBPD) or any member of the staff or employee thereof, use and disclosure of the above-named patient's protected health information to carry out treatment, payment activities and healthcare operations. This form is used to obtain acknowledgement that you have been notified that our Notice of Privacy Practices can be obtained from our office.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. This notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of the above-named patient's protected health information, and of other important matters about the above-named patient's 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 EBPD at 732 238-5100.

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 EBPD. 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, the above-named Patient / Parent(s) / Legal Guardian(s) / Personal Representative have had full opportunity to read and consider the contents of this Consent form and EBPD Notice of Privacy Practices.

I understand that, by signing this Consent form, I am giving my consent to EBPD to use and disclosure the above-named patient's protected health information to carry out treatment, payment activities and health care operations. In addition, I give permission to EBPD to speak with either parent or either legal guardian concerning the above named patient's protected health information to carry out treatment, payment activities and health care operations. I acknowledge receipt of EBPD Notice of Privacy Practices.

In addition to the above I also give permission to EBPD to speak with the following person (s) concerning the above-named patient:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

If a Parent/Guardian/Personal Representative signs this consent on behalf of the Patient please complete the following:

Print Name of Parent/Legal Guardian/Personal Representative: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT., PLEASE ADVISE US IF YOU WANT A COPY.

For Office Use:

Office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

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Patient's Name: _____

We want to welcome you to our dental family. We pride ourselves in a family-oriented environment. In order to provide your child with the highest quality of care please read the information below and ask any questions about anything you do not understand.

Anxiety Reducing Techniques
All effort will be made to obtain the cooperation of our dental patients by the use of Tell–Show-Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient from causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

Tell–Show-Do: The dentist or dental team explains to the child what is to be done using simple kid friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. The procedure is then preformed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back or a prize.

Mouth Props/Rubber Dams: A mouth prop or "tooth pillow" as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc.) This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area to be worked on to isolate the teeth and prevents any debris from being swallowed or going to the back of the throat.

Immobilization by the Dentist: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

Immobilization by the Assistant: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child's hands, stabilizes the child's head and or legs.

Relaxation Gas: Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer, and allows the treatment to be completed in a comfortable manner for the child.

Insurance- Please understand that we accept insurance as a courtesy. We are happy to help with the process of submitting claims. However, understanding your insurance is ultimately your responsibility. The estimated out of pocket payment is due at the time of service.

Late and Missed Appointments- Please be aware that there is a charge of $75 dollars for a missed appointment without 48 hours' notice. Three missed appointments will result in discharge from our practice. In order to provide an on-time schedule of services, we ask you to be 10 minutes early to all appointments. If you are more than 10 minutes late, you may be asked to reschedule your appointment.

Copies of X Rays-We are always happy to provide you with copies of your child's X Rays. There is a charge of $25 dollars for all X Rays.

I authorize the Doctors and the Dental staff at East Brunswick Pediatric Dentistry to perform the necessary dental services my child may need including, but not limited to, the use of nitrous oxide, x-rays, prophylaxis and fluoride treatment.

I_____ acknowledge that I have read the above and agree to the contents.

Printed Name of Parent//Legal Guardian/ Representative

_____ _____ _____

Signature Parent/Legal Guardian/Representative Date

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SUPPLEMENTAL INFORMED CONSENT
DENTAL TREATMENT IN THE ERA OF COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19 also known as "Coronavirus," at any time or any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office just as you might be at a grocery store, pharmacy or restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible in our practice to maintain social distancing between the patient, pediatric dentist, dental staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment? Yes No

_____	_____	_____
Signature Parent/Legal Guardian	Relationship to Patient	Date