Newburyport PC
PEDIATRIC DENTISTRY
LINDI J. EZEKOWITZ, D.D.S.
ROSALYN M. SULYANTO, D.M.D.

7 GRAF ROAD
SUITE 2A
NEWBURYPORT, MA 01950
(978) 462-2227

Dear Parents/Guardians,

Thank you for choosing Newburyport Pediatric Dentistry for your child's oral health needs! We appreciate your decision and we want to make your child's first visit to our office a positive and enjoyable experience. We look forward to working together and providing the best possible oral health care for your family.

We are able better to serve you if you bring the following items to the appointment:

- All necessary paperwork filled out and signed
- Your insurance card, or printed information from your insurance company
- A photo ID
- X-rays and Records from the patient's previous dental office

By arriving 15 minutes prior to the reserved appointment time with all of the above information, it will allow our office time to process your paperwork and have the full reserved time to diagnose and treat the patient completely.

Prior oral health history is essential in a first visit to a new office. Please contact the previous dental provider's office and have your child's dental x-rays and records sent to our office before your first visit. These records can be emailed to info@newburyportsmiles.com or hand carried to our office. We appreciate your effort in getting these to us as it gives the doctor a complete oral health picture and you can avoid additional charges for things you have already done.

Your initial visit is an important one. It is a time for us to get to know each other. Everything we do will be explained and shown as we teach your child how to keep their smile healthy. You can help make your child's visit a successful experience in a few ways. First, please feel at ease and relaxed, as any anxiety on your part will be transferred to your child. Second, we are very selective in our use of words. Please be supportive of our terminology and tell your child that we will count their teeth, show them how to brush, and possibly take a picture. It is important that you should avoid any mention of fear provoking terms such as hurt, drill, pull or needle.

Parents will be asked to accompany children under age 4 into the treatment area. If your child is over 4 and you wish to observe their visit, we ask that you stand at the back of the treatment room. To help ensure a positive visit, we must establish a direct relationship with your child, which means the doctor or hygienist, will be giving information and directions to your child. You can continue helping by acting as a "silent partner" during the visit.

Your aims as a parents and our goals as a pediatric dental team are the same; we want to keep your child's teeth and mouth in good health and make the process of doing so pleasant for all of us. We look forward to meeting you and your child.

Sincerely,

Dr. Lindi Ezekowitz and Staff

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New Patient Information

Who may we thank for referring you?_____ Date:_____

Patient Name: _____ **Nickname:** _____ ☐ **Male** ☐ **Female**

Birthdate: _____ **Age:** _____ **Social Security #:** _____

Home Address: _____

Siblings We Treat: _____ **Which school does child attend?** _____

Who is completing the patient registration forms? _____ **Relationship:** _____

Do you have legal custody of this child? ☐ Yes ☐ No **Is patient adopted?** ☐ Yes ☐ No

Emergency Contact Person & Phone #: _____

Parent/Guardian

Name: _____ ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Guardian

Birthdate: _____ **Social Security #:** _____ **Driver's License #:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Address: _____

Employer: _____ **Occupation:** _____

Parent/Guardian

Name: _____ ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Guardian

Birthdate: _____ **Social Security #:** _____ **Driver's License #:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Address: _____

Employer: _____ **Occupation:** _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Other

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

Person Responsible for Account: _____ **Relationship:** _____

Billing Address: ☐ (check if same as patient)

Home #: _____ **Cell #:** _____ **Work #:** _____

Email Address: _____

Dental Insurance Information

Primary Insurance: _____ **Phone#:** _____ **Address:** _____

Subscriber: _____ **DOB:** _____ **Employer:** _____

ID #: _____ **Group #:** _____

Secondary Insurance: _____ **Phone#:** _____ **Address:** _____

Subscriber: _____ **DOB:** _____ **Employer:** _____

ID #: **Group #:**

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Medical History Form

Patient's Name: _____ **Birth Date:** _____ **Age:** _____

Child's Physician & Phone #: _____

Has the child ever had any of the following?

Condition		If "yes", explain.	Condition		If "yes", explain.
Anemia or Blood Disorder	☐ Yes ☐ No		Fainting or Dizziness	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No		Growth & Development Problems	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No		Hearing/Speech Problems	☐ Yes ☐ No	
ADD or ADHD	☐ Yes ☐ No		Heart Disease	☐ Yes ☐ No	
Autism	☐ Yes ☐ No		Heart Murmur	☐ Yes ☐ No	
Behavioral Disorder	☐ Yes ☐ No		Hemophilia	☐ Yes ☐ No	
Bladder Conditions	☐ Yes ☐ No		History of Abuse	☐ Yes ☐ No	
Blood Transfusions	☐ Yes ☐ No		Hyperactivity	☐ Yes ☐ No	
Birth Defects	☐ Yes ☐ No		Hepatitis or Liver Disease	☐ Yes ☐ No	
Bone or Joint Problems	☐ Yes ☐ No		Immune Disorders (AIDS, ARC, HIV)	☐ Yes ☐ No	
Brain Injury	☐ Yes ☐ No		Leukemia	☐ Yes ☐ No	
Bruising Easily	☐ Yes ☐ No		Intellectual Disability	☐ Yes ☐ No	
Cancer or Malignancies	☐ Yes ☐ No		Neurological Problems	☐ Yes ☐ No	
Cerebral Disorder	☐ Yes ☐ No		Nutritional Deficiency	☐ Yes ☐ No	
Chronic Adenoid/Tonsil Infections	☐ Yes ☐ No		Oral Ulcers	☐ Yes ☐ No	
Chronic Headaches	☐ Yes ☐ No		Orthopedic Problems	☐ Yes ☐ No	
Chronic Ear Infections	☐ Yes ☐ No		Premature Birth	☐ Yes ☐ No	
Cleft Lip/Palate	☐ Yes ☐ No		Rheumatic Fever	☐ Yes ☐ No	
Convulsions/Seizures	☐ Yes ☐ No		Scoliosis	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Sickle Cell Anemia	☐ Yes ☐ No	
Down Syndrome	☐ Yes ☐ No		Spina Bifida	☐ Yes ☐ No	
Emotional Disturbances	☐ Yes ☐ No		Syndrome	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No		Tuberculosis	☐ Yes ☐ No	
Excessive Bleeding	☐ Yes ☐ No		Visual Impairment	☐ Yes ☐ No	
Excessive Gagging	☐ Yes ☐ No		Other	☐ Yes ☐ No	

List all other ALLERGIES: _____

List all Medications child is currently taking: _____

Any serious medical problems, operations, or hospital stays? 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 the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature **Parent/Legal Guardian's Name (Print)** **Date**

Office USE Only – Medical history reviewed by doctor: _____

Signature **Date**

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Dental History Form

Patient Name: _____ **Today's Date:** _____

Previous Dentist Name & Address: _____

Is this his/her First Dental Visit? ☐ Yes ☐ No **Date of last dental visit?** _____

Reason for your child's visit today? _____

Has your child had any negative dental experiences? If yes, explain. ☐ Yes ☐ No

Please answer the following questions.

Was your child bottle fed? ☐ Yes ☐ No If yes, until what age? _____

Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____

Has your child ever had injuries to his/her teeth, mouth, head, or jaw? ☐ Yes ☐ No If yes, please describe: _____

How often does your child brush? ☐ 1x/day ☐ 2x/day ☐ Other: _____

How often does your child floss? ☐ 1x/day ☐ 2x/day ☐ Other: _____

Does your child have any of the following habits? ☐ Finger/Thumb Sucking ☐ Teeth Grinding ☐ Pacifier ☐ Mouth Breather ☐ Tongue Thrusting ☐ Lip Sucking

Does your child receive fluoride in any of the following forms? ☐ Vitamins ☐ Water Supply ☐ Toothpaste ☐ Rinse/Gel ☐ Tablets/Drops Dosage: _____mg/day

Please check any of the following that may describe your child. ☐ Outgoing ☐ Cooperative ☐ High Strung ☐ Defiant ☐ Shy ☐ Anxious ☐ Moody ☐ Stubborn ☐ Trusting ☐ Friendly

How do you expect your child to react to his/her visit today? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't know

How can we help make this a positive experience for your child? _____

Does child have braces or orthodontics? If YES, provide us with Orthodontist's name and location. ☐ Yes ☐ No _____

_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Child's Full Name

Parent/Legal Guardian's Name (Print) **Relationship to Child**

Signature **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please explain)

_____

_____

_____

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FINANCIAL POLICY

Payment Due: The full balance of treatment is due at the time services are rendered. Payment plans are not available from our office. For your convenience we accept cash, check, debit card, American Express, CareCredit®, Master Card, Visa, and Discover.

Financial Responsibility: The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. *A $12.00 rebill fee may be charged on any account that is not paid within fifteen (15) days of the statement date*. If necessary, accounts that are not paid within 60 days may be referred to a collection agency. All reasonable expenses incurred in the collection process will be the account holder's responsibility.

Insurance: We are happy to file dental claims for our families who have dental insurance. In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. *Filing your insurance is not a guarantee of payment*. Please understand that the parent or guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on your child's needs, not on what insurance will pay. We will do everything possible to maximize your benefits.

- Your complete insurance information/card must be presented at the time services are provided and updated as necessary. Most benefits will be verified before your insurance company can be billed however; it is ultimately your responsibility to understand your insurance benefits.
- In the event that your insurance has not paid your account within 60 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.
- We are a participating provider with the following companies: **Altus Dental, Blue Cross Blue Shield of MA, Delta Dental Premier, and MassHealth.**

Required Payments: At dental visits, we collect a percentage of the total cost of treatment, determined by an **ESTIMATION** of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by check in the mail at your request.

Divorce/Separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from them. We will provide you additional copies of receipts if needed. We do not split bills.

Returned Checks: There is a $25.00 fee for any checks returned by the bank.

CareCredit®: A convenient alternative to credit cards, cash or checks, CareCredit® is a health care card that is exclusively utilized for dental and medical services. They offer flexible payment options that fit your timetable and budget. For additional information, contact us or visit www.carecredit.com.

I have read the above policies and understand my obligations with Newburyport Pediatric Dentistry for my child's dental care. I affirm that my signature represents my agreement to all of the terms and conditions mentioned above.

Parent/Legal Guardian's Name (Print) **Relationship to Child**

Signature **Date**

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INFORMED CONSENT FOR PATIENTS

X-Rays and Examination

I understand that my child will be receiving a dental examination from a state licensed and board-certified pediatric dentist. I understand that x-rays maybe taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Initial_____

Medical Photography Consent

I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and dental treatment.

Initial_____

Dental Cleaning and Fluoride Treatment

I authorize the board-certified and state licensed clinical staff at Newburyport Pediatric Dentistry to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps prevent cavities.

Initial_____

Medications

I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

Initial_____

I am aware that my dental insurance company may or may not cover two fluoride treatments and/or oral exams per year and if this service is not paid by my insurance company, I will be financially responsible.

Initial_____

I understand that all of the above treatments are the standard of care in pediatric dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments. I attest the information I have provided is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status

Child's Full Name

Parent/Legal Guardian's Name (Print) **Relationship to Child**

Signature **Date**

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PHOTOGRAPHY RELEASE/CONSENT

Here at Newburyport Pediatric Dentistry, we make every effort possible to make our patients feel special. We love to share pictures of our patients' beautiful smiles on our Facebook page, website, and other office related materials for our friends and family to see just how much fun a visit to the dentist can be! Please check one of the following boxes and sign below.

☐ **I AGREE** and hereby grant full permission to Newburyport Pediatric Dentistry, Dr. Lindi Ezekowitz and staff to use either myself or my child/children's name(s) and photograph in any publication or advertising materials (printed or electronic), and social media. This consent serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or my child's photograph or name.

IF YOU AGREE, be sure to follow our social media sites to see your child's smile!

www.NewburyportSmiles.com

www.facebook.com @Newburyport Pediatric Dentistry

☐ **I DO NOT AGREE** to have mine or my child/children's name(s) photograph used for public viewing.

Child/Children's Full Name

Parent/Legal Guardian's Name (Print) **Relationship to Child**

Signature **Date**

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CAREGIVER CONSENT FORM FOR TREATMENT OF A MINOR

It is the policy of Newburyport Pediatric Dentistry that all minors be accompanied by a parent or legal guardian for their dental visits. We understand, however, that there may be times when another caregiver may accompany them.

A parent or guardian MUST be present for your first visit with our office. After this initial appointment, a minor may be brought in by another caregiver. That person may be a babysitter, older sibling, or other family member and must be 18 years or older. If we do not have this consent on file, except in emergency situations, we reserve the right to reschedule your child's appointment. IF this caregiver has Power of Attorney and/or legal decision making for your child, please bring that documentation to your child's appointment so that we have it on file.

I, the undersigned, as the parent of legal guardian, herby authorize the below named caregiver(s) to be present for my child's dental visits.

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

In the event of any issues or concerns, I understand that a reasonable attempt will be made to contact a parent or legal guardian. However, if I am not available, I authorize the above persons to make the necessary decisions on my behalf

_____

Child/Children's Full Name

_____

Parent/Legal Guardian's Name (Print) **Relationship to Child**

_____

Signature **Date**