76 Bellevue Avenue
Montclair, New Jersey 07043
Tel: (973) 744-3127 Email: kidsparkle@gmail.com Fax: (973) 744-3128

Child's Name:
*Last:_________________________________ *First:____________________________ Middle:______________________

*DOB:____________ Age:______ M:_____ F:_____ School: ________________________________ Grade:____________

RESPONSIBLE Parent:
Last Name: ____________________________________ First Name:____

*Address: ____
Street City State Zip Code

*Home Phone: ________-________-_________ *Cell: _______-_______-_______ *E-mail: __________________________

*SOCIAL SECURITY #: ______________-_____________-_______________ *DOB: __________/________/____________

INSURED Parent:
Name:____ SS #: ________-_______-________* DOB:__________________

*Employer Name: ____ *Phone #: _______-_______-________

*Insurance Company (if any):_______________________________________*Group Number: ________________________

If other than Responsible or Insured Parent: __________________________ Relationship to child:___________________

SOCIAL SECURITY #: ____________-__________-____________ DOB: ___________/___________/_______________

Address: ________________________________City:________________ State:____ Zip:_____ Phone:__________________

Insurance Company ______________________Employer _______________________ Group Number ___________________

Child's Special Interests? ____

Any Special Circumstances?____

*How did you hear about Sparkles? ____

Date of last visit to dentist was? ___________________ For what treatment? _____________________________________

IS YOUR CHILD REQUIRED TO PREMEDICATE BEFORE APPOINTMENTS? (CIRCLE ONE) YES NO

If Yes, Describe reason for Premedication: ____

(*) Information needed for payment purposes. Claims cannot be sent without this important information.

DENTAL HISTORY

	YES	NO
Does your child brush teeth daily?	_____	_____
Has child complained about dental problems?	_____	_____
Experience unhappy dental experiences?	_____	_____
Any mouth habits -thumb sucking, nail biting, mouth breathing, nursing, bottle, pacifier, etc.?	_____	_____
Any unusual speech habits?	_____	_____
Do you assist child with tooth brushing?	_____	_____
Is dental floss used?	_____	_____
Is fluoride taken in any form?	_____	_____
Any injuries to mouth/teeth/head?	_____	_____

HEALTH HISTORY

Child's Physician: ____

Address: ____ **Phone:**__________________________

Date of last physical examination: _______________________ **Results:**____

	Yes	No
Is your child receiving any medication or drugs , other than vitamins?	_____	_____
Is their any excessive bleeding when cut?	_____	_____
Has your child ever been hospitalized or had surgery?	_____	_____
Does your child have any allergies?	_____	_____
Does your child have any special needs or disabilities?	_____	_____

HAS CHILD DIFFICULTY WITH ANY OF THE FOLLOWING: (Please check appropriate box)

	YES	***NO***		***YES***	***NO***
Anemia			Murmur		
Chronic Sinus			Tuberculosis		
Hearing			Cerebral		
Mastoid			Epilepsy		
Rheumatic Fever			Liver		
Asthma			Mononucleosis		
Convulsions			Palsy		
Heart			Chicken Pox		
Measles			Fainting		
Thyroid			Malignancies		
Bladder			Mumps		
Diabetes			Other		
Kidney					

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed (write none if applicable):____

*To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners. I give the doctor permission to use any photographs taken for educational and commercial purposes. I also give permission to obtain copies of records and x-rays from my previous dentist(s)
Dr. ______________________________________.

____ **Date____/_____/_____**
Signature of person completing the form

Reviewed by Dr. ________________________ **Date** _____/_____/________
Sparkles Dentistry for Children, LLC, 76 Bellevue Avenue, Montclair, New Jersey 0704

Financial Policy

Sparkles Dentistry for Children is only in network with Delta Dental Insurance. Therefore if you are covered by any other insurance, you must have OUT OF NETWORK BENEFITS. Payment is due upon treatment. If you have Blue Cross Blue Shield or Aetna you must have a **PPO plan,** no **HMO** or **DMO**. Sparkles Dentistry for Children will submit and process the claim work for you, and make every effort to ensure that the reimbursement is sent to you.

INSURED PARTIES ONLY: I hereby authorize payment directly to Sparkles Dentistry for Children of the group insurance benefits otherwise payable to me. I understand I am financially responsible for any charges not covered by my insurance(s). I authorize release of any information relating to my dental benefits and claims.

____ Date____/_____/____
Insured's Signature

Cancellation Policy:

If you need to cancel or reschedule your appointment, I would like to remind you that we require 48 hours notice to avoid a $50.00 broken appointment fee. When appointments are cancelled without advance notice, it causes a gap in our schedule, which we are unable to fill. More importantly, it prevents us from seeing other children, who on average wait three to four weeks for an appointment.

While we understand that schedules are unpredictable, we appreciate your cooperation in this matter, and look forward to seeing you.

***Continued on back**