ACQUAINTANCE FORM **TODAY'S DATE** _____

Patient's Name _____ Sex: M/F Nickname: _____
Birthdate _____ Age _____ School _____ Grade _____
Patient's Brothers/Sisters & Ages _____
Patient's Favorite Pet, Friend, or Toy _____
Is your child adopted? _____

Father or Guardian's Name _____ Marital Status _____
Birthdate _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Employer _____ Position _____ Years _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Extension _____

Mother or Guardian's Name _____ Marital Status _____
Birthdate _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Employer _____ Position _____ Years _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Extension _____

I give my consent to leave a message here if I am unavailable:
Name _____ Relationship _____ Number _____
Name _____ Relationship _____ Number _____

I was referred to Kids Dental Kare by _____

****If you have DENTAL INSURANCE, please provide a copy of the card to the front desk staff!**
Policy Holder _____ Group Name _____
Insurance Company _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Member ID _____ Group Number _____ Effective Date _____

Secondary Dental Insurance
Policy Holder _____ Group Name _____
Insurance Company _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Member ID _____ Group Number _____ Effective Date _____

Medical History
Physician _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Date of Last Visit _____
Any Hospitalizations (When & Why) _____
Any Surgeries (When & Why) _____
Any Current Medications _____
Allergies _____
***Up to Date with Vaccinations?* YES** _____ **NO** _____ (If no, please explain: _____
_____)

Has your child ever had a **REACTION** to any of these drugs?

YES	NO		YES	NO		YES	NO	
____	____	Codeine	____	____	Local Dental Anesthesia	____	____	Tylenol
____	____	Nitrous Oxide	____	____	Sulfa	____	____	Other: _____
____	____	Penicillin						_____

Has your child ever had any of these conditions?

YES	NO		YES	NO		YES	NO	
____	____	ADD/ADHD	____	____	Diabetes	____	____	Hyperactivity
____	____	AIDS	____	____	Down Syndrome	____	____	Intellectual Disability
____	____	Anemia	____	____	Epilepsy	____	____	Liver Disease
____	____	Arthritis	____	____	Fainting	____	____	Pneumonia
____	____	Asthma	____	____	Fragile X Syndrome	____	____	Prolonged Bleeding
____	____	Autism	____	____	Hepatitis	____	____	Rheumatic Fever
____	____	Blood Pressure	____	____	Hearing Impairment	____	____	Severe Infections
____	____	Blood Transfusions	____	____	Heart Murmur	____	____	Tourette Syndrome
____	____	Cancer	____	____	Heart Trouble	____	____	Thyroid Issues
____	____	Convulsions	____	____	Hemophilia	____	____	Tuberculosis

Other: _____

Does your child have any psychological or emotional problems that you feel should be brought to our attention? _____

_____

Has your child ever had any experiences with other health professionals that have been unpleasant? _____

_____

Any other information that you consider important? _____

1. Current Oral Conditions:
   a. Does your child suck his/her thumb, fingers, or blankets? _____
   b. Has your child experienced any sores in or around his/her mouth? _____
   c. Does your child have any speech problems? _____
   d. Does you feel your child may have:
      i. Cavities? _____
      ii. Gum Disease? _____
      iii. Crooked Teeth (Malocclusion)? _____
      iv. Other? _____
   e. Do you desire complete oral care for your child? _____
      If not, are there any specific issues you would like us to treat? _____
2. Current Oral Habits:
   a. Does your child receive fluoride in any of the following forms?
      Water ____ Toothpaste ____Vitamin Drops ____ Tablets ____ Rinses ____ Other _____
   b. Brushing:
      i. Toothbrush: Soft ____ Medium ____ Hard ____ Frequency Per Day: _____
      ii. Do you assist your child? _____ How often? _____
      iii. Does your child floss? _____ How often? _____
   c. Snack Food: _____
   d. Has your child ever taken a bottle to bed? _____ Contents? _____
3. Previous Dental Experience: (If first visit to any dentist, please check □)
   a. Name of Previous Dentist: _____
   b. Date of Last Visit: _____ Was Treatment Completed? _____
   c. Was the experience pleasant? _____
   d. Were x-rays taken? _____ Date: _____ Amount: _____
   e. Has your child seen an orthodontist? _____
   f. Has anyone in your family needed orthodontic treatment? _____

Completed by: _____ Relation to Patient: _____

- I authorize release of information relating to a claim to Kids Dental Kare.
- I understand that I am responsible for all costs of dental treatment.
- I hereby authorize payment directly to Dr. Jay Felsenstein from my group insurance benefits, if applicable.
- I have received a copy of the Notice of Privacy Practices.

Signature _____

KIDS DENTAL KARE
Consent for Disclosure of Protected Health Information (HIPAA)

SECTION A: Patient/ Parent/ Legal Guardian Giving Consent

Patient Name: _____

Date of Birth: _____

SECTION B: Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent 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 consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your 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, 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 requesting it from us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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 will decline to treat you or to continue treating you if you revoke this consent.

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 or my child's protected health information as described in the "Notice of Privacy Practices."

Signature: _____

Today's Date: _____

Relationship to Patient _____

Other person(s) to whom you give permission to discuss health information or bring child to routine care appointments:

Name: _____
Relationship to patient: _____
Phone number: _____

Name: _____
Relationship to patient: _____
Phone number: _____

Kids Dental Kare Informed Consent

Potential Risks and Limitations of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to insure the best possible care.

Throughout life teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare up during any dental treatment, and may require endodontics (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

I understand that during treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

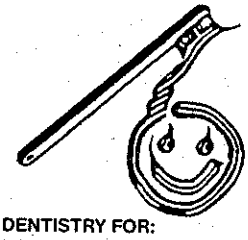
I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Excellent oral hygiene
2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification: who are constantly late for their appointments: who continue to excessively cancel their appointments: who fail to practice acceptable oral hygiene: or who are uncooperative with staff providing care.

Signature _____ Date: _____



DENTISTRY FOR:
TODDLERS • CHILDREN
ADOLESCENTS

Kids Dental Kare

4521 ROUTE 9 NORTH, HOWELL, NEW JERSEY 07731
732-905-0808 • FAX 732-905-0312
www.kdkinhowell.com

Jay Felsenstein D.D.S.
Pediatric Specialty #3282

Shaina Felsenstein D.M.D.
Pediatric Specialty #6426

Office Policy

All parents/guardians must read and sign this form BEFORE seeing the doctor.

A Minor (anyone under the age of 18 years old) must be accompanied by a parent or guardian. The adult accompanying the minor is responsible for full payment. We cannot, and do not, get involved in divorce and custody matters.

Appointment Policy

A 24 hour notice of a cancellation is greatly appreciated.

- Cancelling an appointment = a telephone call to our office
- Broken appointment = not showing up for a scheduled appointment. This results in or can result in a broken appointment fee of $65.00 to $100.00
- Please take note that our office telephone answering machine is on 24 hours a day, 7 days a week, (732)905-0808.

We do our best to confirm appointments, but ultimately it is the responsibility of the **parent** to keep an appointment. We pride ourselves on running on time and if a patient is late, we use the discretion of the Office Manager to reschedule if necessary.

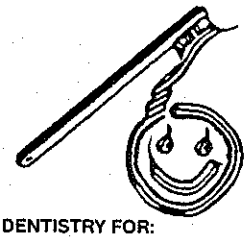
Missed appointments are handled at the Office Manager's discretion. We record all conversations and cancellations in our files. We reserve the right to charge at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

Please Note: Our office is open during school and camp hours. We can provide school/work notes if necessary.

I have read the "Office Policy" in full and understand the office policies. I agree to these terms.

Parent or Guardian Signature: _____

Date: _____



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Financial Policy

It is our office policy that payment is expected IN FULL when treatment is rendered. Methods of payment include: Cash, Personal Checks, Visa, Mastercard, Discover, American Express, and Care Credit.

Our office is contracted with Delta Dental Premier, Cigna Radius, and Horizon Blue Cross Blue Shield Traditional. It would be our pleasure to "work" with your insurance. (N.J. Carpenters and any Local companies do not apply). You will be asked to leave a percentage (estimated 25%) as services are rendered. Ultimately it is the parent's responsibility to know their insurance as each plan is specific. Kids Dental Kare is not liable for procedures not covered. You will also leave a credit card number on account so that balances (if any) could be cleared up. If there is a credit on the account we will be happy to issue you a check or leave the credit on account for future visits.

PLEASE NOTE: IF WE ARE ASKED TO RESUBMIT YOUR CLAIM, THERE IS A NOMINAL FEE ADDED TO YOUR ACCOUNT. WE DO NOT GUARANTEE THAT YOUR INSURANCE COMPANY WILL PAY FOR THE USUAL AND CUSTOMARY FEES OF THIS OFFICE, NOR WILL WE ENTER INTO DISPUTE WITH YOUR INSURANCE COMPANY OVER REIMBURSEMENT.

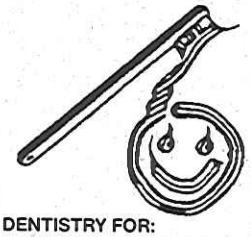
Name on Card

American Express ___ Discover ___ Mastercard ___ Visa ___

Card Number Expiration Date CVC Code

Signature Date

Billing City & Zip Code



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Jacklyn Brown D.D.S.
Pediatric Specialty #6643

COVID19 RISK - CONSENT FORM

Responding to the public health hazard posed by Coronavirus disease 2019 ("COVID-19"), effective 5:00 p.m. on Friday, March 27, 2020, Governor Philip D. Murphy ordered and directed the suspension of all surgeries or invasive procedures that can be delayed without undue risk to the current or future health of the patient as determined by the patient's treating physician or dentist.

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that Kids Dental Kare desires to protect the safety of our office and the patients, staff, and other individuals who come upon the premises.

Accordingly, as a precondition to rendering treatment, I have confirmed that neither I, nor my child, have symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that neither I nor my child, have within the past 14 days, travelled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 50 or more persons, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19. I consent to the performance of the treatment proposed by Dr. Jay Felsenstein and/or Dr. Shaina Felsenstein.

Patient(s) Name(s): _____

Parent Name: _____

Signature: _____

Date: _____

Initial here _____ if any person **in my household becomes infected with COVID19 within 14 days of today's visit I acknowledge that I must notify Kids Dental Kare immediately.**