New Patient Packet

A PARENT or LEGAL GUARDIAN of the child must complete this form.

PATIENT INFORMATION

Name of Patient:

_____

Nickname: _____ **DOB:** _____ **Gender:** ☐ **M** ☐ **F**

Primary Address of Patient: **City:** **State:** **Zip:**

_____ _____ _____ _____

Primary Phone number: _____ **Primary email:** _____

PARENT INFORMATION

LEGAL GUARDIAN (I)

☐ Biological Mother ☐ Biological Father ☐ Other _____

Name: **DOB:** **SS#:**

_____ _____ _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Primary Phone: _____ **Secondary Phone:** _____ _____

Work Phone: _____ **Email:** _____

☐ Check box if Address is same as patient's listed above.

Street Address: **City:** **State:** **Zip:**

_____ _____ _____ _____

LEGAL GUARDIAN (II)

☐ Biological Mother ☐ Biological Father ☐ Other _____

Name: **DOB:** **SS#:**

_____ _____ _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Primary Phone: _____ **Secondary Phone:** _____ _____

Work Phone: _____ **Email:** _____

☐ Check box if Address is same as patient's listed above.

Street Address: **City:** **State:** **Zip:**

_____ _____ _____ _____

Who does the patient live with?: ☐ **Guardian 1 & 2** ☐ **Guardian 1** ☐ **Guardian 2** ☐ **Other:** _____

Is there a custody arrangement: ☐ **YES** ☐ **NO**

If there is a court order specifying custody arrangement for primary responsibility, you need to provide that documentation.

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Policy Holder:

_____

DOB: **SS#:** **Relation to the patient:**

_____ _____ _____

ID / Policy #: **Group No:**

_____ _____

Insurance Company Name: **Phone:**

_____ _____

☐ Employee Plan ☐ Retiree ☐ Self-funded ☐ State/Medicaid

SECONDARY COVERAGE

Policy Holder:

_____

DOB: **SS#:** **Relation to the patient:**

_____ _____ _____

ID / Policy #: **Group No:**

_____ _____

Insurance Company Name: **Phone:**

_____ _____

☐ Employee Plan ☐ Retiree ☐ Self-funded ☐ State/Medicaid

REFERRAL INFORMATION

How did you hear about Halex Pediatric Dentistry?

☐ **Patient:** _____ ☐ **Social Media:** _____ ☐ **Doctor/Dentist:** _____ ☐ **Other:** _____

I certify that the information I have given is correct to the best of my knowledge. The information will be held in confidence and it is my responsibility to inform Halex Pediatric Dentistry of any changes in the patient's medical status. I authorize the release of all information necessary to secure benefits otherwise payable to me. I directly assign Dr. H. Bobby Garofalis and his associates all insurance payments otherwise payable to me. I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to, third party collection fees. I affirm that my signature represents my agreement to all the terms mentioned above.

Parent/Guardian Signature: **Relation to Patient:** **Date:**

_____ _____ _____

New Patient Packet

NAME OF PATIENT: _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit?: ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay

Has your child ever been to the dentist? ☐ Yes ☐ No **Last Exam Date:** _____

Has your child had dental X-rays in the past six months? ☐ Yes ☐ No **Date of Last X-Rays:** _____

Has your child ever complained about a dental problem, or had an unhappy dental experience you would like to share with us?

☐ **Yes** ☐ **No** **Explain:** _____

Please list any dental concerns you would like to discuss today: _____

DENTAL HABITS

Does your child currently: (check all that apply)

☐ Suck Thumb/Finger	☐ Suck/Bite Lips	☐ Bite/Chew Nails	☐ Tongue Thrust	☐ Bottle Feed
☐ Use Pacifier	☐ Tongue/Cheek Chew	☐ Clench/Grind Teeth	☐ Mouth Breather	☐ Breast Feed

HYGIENE ROUTINE

(check all that apply)

☐ Fluoride Toothpaste	☐ Consume Fluoridated Water	☐ Brushing by Child: ____ /day	☐ Snack between Meals
☐ Fluoride Mouthwash	☐ Dental Floss: ____ /week	☐ Brushing by Parent: ____ /day	Type of snacks: _____

MEDICAL HISTORY

Are immunizations current: ☐ Yes ☐ No

Child's physician: **Phone:** **Date Last Exam:**

_____ _____ _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain):

_____

Current Medications: _____

Has your child been diagnosed and/or treated for any medical conditions?

YES | NO		YES | NO		YES | NO	
☐	☐ Complications before/at birth, prematurity, inherited conditions, syndromes, or birth defects	☐	☐ Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐	☐ Cancer, tumor, or other malignancy; chemotherapy, radiation, or transplant
☐	☐ Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	☐	☐ Prolonged diarrhea, unintentional weight loss, weight concerns, or eating disorder	☐	☐ Behavioral, emotional, communication, or psychiatric problems/treatment
☐	☐ Sinusitis, chronic adenoid/tonsil infections	☐	☐ Bladder or kidney problems or bedwetting	☐	☐ Attention deficit/hyperactivity disorder (ADD/ ADHD)
☐	☐ Developmental disorders, learning problems/ delays, or intellectual disability	☐	☐ Fine/gross motor deficits, arthritis, limited use of arms/legs, or muscle/bone/joint problems, or scoliosis	☐	☐ Abuse (physical, psychological, emotional, or sexual) or neglect
☐	☐ Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	☐	☐ Recurrent headaches/migraines, fainting, or dizziness	☐	☐ Precocious puberty or hormonal problems
☐	☐ Irregular heartbeat or high blood pressure	☐	☐ Diabetes, hyperglycemia, or hypoglycemia	☐	☐ Thyroid or pituitary problems
☐	☐ Asthma, reactive airway disease, wheezing, or breathing problems	☐	☐ Impaired vision, visual processing, hearing, or speech	☐	☐ Anemia, sickle cell disease/trait, or blood disorder
☐	☐ Cystic fibrosis	☐	☐ Problems with physical growth or development	☐	☐ Hemophilia, bruising easily, or excessive bleeding
☐	☐ Frequent colds/coughs, bronchitis, or pneumonia	☐	☐ Transfusions or receiving blood products	☐	☐ Sleep apnea, snoring, or mouth breathing
☐	☐ Frequent exposure to tobacco smoke	☐	☐ Rash/hives, eczema, or skin problems	☐	☐ Jaundice, hepatitis, or liver problems
☐	☐ Autism/autism spectrum disorder or sensory integration disorder	☐	☐ GERD/acid reflux, stomach ulcer, or intestinal problems	☐	☐ COVID-19, CMV, HIV/AIDS, MRSA, mononucleosis, scarlet fever, STD, or TB
☐	☐ Hydrocephaly or placement of a shunt				

Please explain any "YES" answers:

_____

Other conditions not listed above (please specify):

_____

ALLERGIES	☐ DRUGS	☐ FOOD	☐LATEX	☐OTHER
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

If there is any additional information that you think might be of value to us in treating your child, please feel free to notate it on this form.

I certify that I have read and understand the above questions. The information will be held in confidence, and it is my responsibility to inform Halex Pediatric Dentistry of changes in the patient's medical status.

I will not hold Dr. H. Bobby Garofalis & his associates, or his staff, responsible for any errors or omissions I may have made in the completion of this form.

Parent/Guardian Signature: **Date:**

_____ _____

Halex Front Desk Signature: **Date:**

_____ _____

New Patient Packet

FINANCIAL POLICY

We would like to take this opportunity to thank you for choosing Halex Pediatric Dentistry for your family's pediatric dental needs. We will work very hard to ensure you and your family receive the best care possible with every effort being made to address all your cares and concerns.

Insurance: As a courtesy for our patients we are happy to file dental claims for families with dental insurance. Treatment plans, insurance pre-authorization, spoken statements or filing insurance claims does not guarantee payment from your insurance. Halex Pediatric Dentistry will make no more than 2 attempts to file and settle an insurance claim within 6 months from the date of service. Insurance companies do not guarantee payment until they receive the claim, review it, and process it according to the specific plan allowances, deductibles and co-pays. Therefore, please be informed that our staff will never guarantee coverage/payment by your insurance provider. If a service is considered not covered by your insurance company, the patient will be responsible for the remaining balance. If you do not agree with the denial, you must resolve the matter with your insurance company. Halex Pediatric Dentistry does NOT file claims to Medical Insurance Policies.

Patient's Responsibility: Our doctors recommend treatment based on the patient's needs, not what the insurance will cover. It is the patient's responsibility to know and understand their own dental insurance plan and allowances. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Treatment costs, co-pays, deductibles and non-covered procedures are due at the time services are rendered. When insurance is involved, your remaining balance is due upon settlement of your insurance claim. If your insurance claim is not resolved or settled within 6 months from the date of service, then the account balance becomes your financial responsibility. You have the final responsibility for any services rendered and not covered by insurance. Your insurance information, such as ID cards, legal decrees, or court-orders must be presented to the office and documented with Halex Pediatric Dentistry. It is your responsibility to update us with any insurance changes as they arise.

Payment Due: The full balance of treatment; co-pays, deductibles and non-covered procedures are due at the time services are rendered. Our offices accept cash, checks (under $50), Visa, MasterCard, Discover, American Express and CareCredit (in selected locations). There is a $50 fee for any checks returned by the bank.

Past Due Accounts & Statements: Our billing office sends out monthly statements for all accounts with a balance. Unless prior arrangements have been made through our billing office, balances on accounts are payable when the statement is issued. After three statements have been sent regarding your account balance, we will send a Final Notice stating that you have 10 days to reconcile your account or you will be sent to a third-party collection agency, where you will be financially responsible for all reasonable expenses incurred, including but not limited to, third party collection fees of 33%.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Good Faith Estimate (No Surprises Act). Under federal law, patients who do not have dental insurance, or who are not planning to use dental insurance for a course of treatment, have the right to receive a Good Faith Estimate of the expected cost of that treatment before it is provided. Halex Pediatric Dentistry will provide a written Good Faith Estimate for any recommended treatment upon request, and no later than one business day after scheduling services requested at least three business days in advance. This estimate is not a bill and does not obligate you to proceed with treatment; actual costs may change if your treatment needs change. If your final bill is $400 or more above your Good Faith Estimate, you have the right to dispute the charge. For questions about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

_____ *(Initial)*

APPOINTMENT POLICY

When we schedule an appointment for your child, that time is reserved solely for your child. We will be here to serve your child and in return we expect them to be present for all scheduled appointments. Our doctors and staff value your time and hope you value theirs. We strive to create an appointment schedule that most efficiently provides time for the dental needs of all the patients we serve.

A parent or legal guardian must accompany any child under the age of 18 to all appointments and is required to be present in the office at all times. In order to have someone else accompany the child to appointments, you must first have a permission letter on file granting that individual permission to bring your child to the appointment.

A permission letter is not valid for treatment appointments where the patient is to be administered Conscious Sedation Medication or General Anesthesia.

Arrival Time: Please plan to arrive 10-15 minutes before your scheduled appointment. This will allow time for parking and to complete any additional paperwork required. We strive to see all patients on time for their scheduled appointment.

Canceling or Rescheduling: If you are unable to keep a scheduled appointment, a 48-hour notice is required. We understand that unforeseen emergencies do occur, however, we reserve the right to charge your account a $25 fee for repeated last-minute cancellations or "No Show" broken appointments as follows:

Preventative - If you have two "No Show" or "Cancelled" appointments with less than a 48-hour notice, our office reserves the right to dismiss the patient from our practice or charge a $40 broken appointment fee.

Restorative - Due to the large amount of time reserved and set up required, if missed or cancelled a restorative appointment with less than a 24-hour notice, we reserve the right to charge a $40 broken appointment fee or dismiss the patient from our practice so that we can provide care to other patients. Should you fail to confirm your appointment at least 24 hours ahead, we reserve the right to double book your assigned time slot and discard your priority to be serviced in that appointment.

Confirmations: As a courtesy to our patients, our staff will make personal appointment reminder calls, in addition to our automated text and emailing confirmation system. In the event that we are unable to reach you, please contact our office to confirm that you will be on time for your scheduled appointment.

_____ *(Initial)*

IMPORTANT INFORMATION TO REMEMBER WHEN SCHEDULING YOUR CHILD'S DENTAL APPOINTMENT

- You are **REQUIRED TO CONFIRM** the appointment no later than 48 hours in advance. If the appointment is not confirmed, you will lose your scheduled time. _____ *(Initial)*

- Our office will try to reach you **one week in advance** of the appointment to confirm, and again **one day before the appointment** as a courtesy reminder. Not updating your phone number or not receiving the call/message are not valid reasons for not confirming your appointment. _____ *(Initial)*

- **No call/no shows or last-minute cancellations** (less than 24-hour notice) are immediate grounds for dismissal from all Halex Pediatric Dentistry locations. _____ *(Initial)*

- A Parent or Legal Guardian **must be present** for the entirety of the appointment. _____ *(Initial)*

- **No Third Party** (grandparents, uncle, cousins, stepmom, boyfriend, etc.) is allowed to accompany the patient **unless there is a permission letter on file or paperwork indicating custody/power of attorney**. Third parties must provide photo ID to verify they are the persons granted permission to bring the patient. _____ *(Initial)*

I have read the above Financial and Appointment Policies. I understand my obligations with Halex Pediatric Dentistry. I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable cost and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees, and attorney fees. I affirm that my signature represents my agreement to all the terms mentioned above.

Patient's Name:

_____

Guardian Print Name: _____ **Guardian Signature:** _____ **Date:** _____

Halex Front Desk Signature: _____ **Date:** _____

Notice of Privacy Practices
Acknowledgment and Consent

PATIENT'S NAME	

DENTAL TREATMENT CONSENT

I authorize Dr. H. Bobby Garofalis & Associates and staff to perform or assist with the following (not an exhaustive list):

• Dental Examinations • Extractions/Oral Surgery • Emergency Dental Treatment • Prophylaxis (Cleaning), X-rays, Fluoride Treatments • Space Maintenance/Interceptive Orthodontics • Fillings • Crowns • Sealants • Endodontics/Nerve Treatments • Other

The purpose of the above is to maintain dental health and we anticipate that result. No guarantees or assurances can be made as to the results that may be obtained. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tones. I understand that should the child become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such movements, it may be necessary to use physical restraints, such as a papoose board. The parent or guardian will be informed of the need for physical restraint and will be asked to assist with placing their child in such restraint.

PARENT/LEGAL GUARDIAN (*PRINT NAME*)	RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers, conduct normal dental care operations such as quality assessments and physician certifications.
I have had the opportunity to understand *Halex Pediatric Dentistry Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my dental health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or dental and healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.
Photo, Video, and Image Consent. As part of providing care, our clinical team may take photographs, x-rays, or video of your child's teeth, mouth, or face for diagnosis, treatment planning, and the clinical record. This clinical use is a standard part of dental care.
Unless you check the box below, you are also giving Halex Pediatric Dentistry permission to use photos or video of your child in materials such as our website, social media, patient education displays, or other promotional materials. We will never publish your child's full name alongside an image without your separate written permission.
☐ **I do NOT give permission** for my child's photo or video to be used for marketing or promotional purposes. (Clinical photos and x-rays will still be taken and used for treatment and record-keeping.)
This authorization may be revoked in writing at any time; revocation will not affect materials already published before the date of revocation. Declining marketing use will not affect the quality of care your child receives.
Communication Consent. To help keep appointments on schedule, Halex Pediatric Dentistry may contact you by phone call, text message (SMS), and/or email regarding appointment reminders, confirmations, treatment follow-up, billing, and other matters related to your child's care. Text messages and emails are not a secure, encrypted method of communication, and message/data rates from your carrier may apply. By providing your phone number and email address on this form, you consent to receive calls and text messages from our office, including from an automated system, at the number(s) and address provided, even if that number is registered on a Do-Not-Call list. Consent to receive text messages is not a condition of receiving treatment.
☐ **I do NOT consent to text message communication**. (You may still receive phone calls and/or mailed communication.)
You may withdraw this consent at any time by notifying our office in writing or by phone.

PARENT/GUARDIAN SIGNATURE	DATE

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

DATE	INITIALS	REASON

PRE-VISIT ACKNOWLEDGEMENT & CODE OF CONDUCT AGREEMENT

Halex Pediatric Dentistry and Orthodontics is committed to providing a safe, respectful, and high-quality environment for every child, family, and team member. A calm, cooperative atmosphere allows our clinical staff to focus fully on your child's care. Before treatment begins, all parents and guardians must read and agree to the expectations below.

Behavior Expectations: We ask that all parents, guardians, and accompanying family members:

- Communicate respectfully with our doctors, hygienists, assistants, and front-office staff at all times, even when discussing concerns, delays, or billing issues.
- Follow the instructions of clinical staff during appointments, including guidance about where to sit, how to support your child, and when to step in or step back.
- Maintain a calm, low-noise environment in treatment areas and the waiting room, as loud conversations, phone calls, or arguments can frighten pediatric patients and disrupt care for other families.
- Supervise other children or siblings who accompany the patient, so they do not disrupt treatment areas or endanger themselves.
- Refrain from photographing, recording video, or livestreaming inside clinical areas without staff permission, out of respect for the privacy of other patients and families present.
- Arrive on time and communicate promptly if you need to cancel or reschedule, so we can care for your child and other patients without unnecessary delay.
- Follow office safety and infection-control protocols, including any posted guidelines regarding illness, visitor limits, or waiting-room conduct.

Zero Tolerance Policy: Halex maintains a zero tolerance policy for behavior that threatens the safety, dignity, or well-being of our patients, families, or staff. This includes, without limitation:

- Verbal abuse, yelling, profanity, or threatening language directed at staff, other patients, or other families.
- Physical aggression, intimidation, or threats of violence of any kind.
- Discriminatory, harassing, or derogatory remarks based on race, color, national origin, sex, age, disability, or any other protected characteristic.
- Disruptive behavior that interferes with the safe delivery of care to your child or to other patients.
- Refusal to follow reasonable safety or clinical instructions from staff during treatment.

If this conduct occurs, staff may terminate the visit immediately for the safety of everyone present. Depending on the severity and frequency of the conduct, Halex reserves the right to dismiss the family from the practice, with or without prior warning, and to decline to reschedule future appointments. Where conduct rises to the level of a genuine safety threat, Halex may also contact building security or local law enforcement.

This policy is not intended to discourage parents from voicing legitimate concerns about their child's care, billing, or scheduling. We welcome that feedback and ask only that it be raised respectfully with our team.

Acknowledgement

By signing below, I acknowledge that I have read and understood this Code of Conduct. I agree to follow these expectations during all visits to Halex Pediatric Dentistry and Orthodontics. I understand that violations may result in the immediate termination of a visit and, at the practice's discretion, dismissal of my family from the practice without further notice.

Parent/Guardian Name: _____

Signature: _____

Permission Letter

To whom it may concern,

I, _____ **am the** _____
Print Parent / Legal Guardian Name *Relationship to Patient*

of the below listed minor child/children:

_____

_____

_____

_____

I hereby give my legal consent for the above listed minor child/children to receive dental care (cleanings, x-rays, and/or treatment), throughout the offices of Halex Pediatric Dentistry, while under the supervision of the below listed adults:

_____

_____

_____

_____

This document allows the aforementioned **to be the responsible party to give medical/dental authorization for the child/children** that are being seen in this office. If treatment is subject to change, I give full permission for the responsible party listed above to give consent to do so.
By signing, I am also acknowledging that this document **is VOID for SEDATION and GENERAL ANESTHESIA dental appointments**—I am fully aware that for those types of appointments a PARENT/LEGAL GUARDIAN MUST be present.

Signed,

_____ _____ _____
Parent / Legal Guardian Signature *Date* *Print Parent / Legal Guardian Name*