971 Route 45 Suite
102 Pomona, NY
10970
(845) 362-2200

GLAD Dental

Dr. Sayeh Naem DDS

Veronica Tadros,
DDS Board
Certified Pediatric
Dentistry

sayehnaemdds@gmail.com

We are thrilled to welcome you and your family and look forward to working with you to maintain your child's oral health. Please fill out this form as completely as possible. If you have any questions, we will be happy to help.

Tell Us About Your Child

Child's Name _____ ❑M ❑F
Last First MI

Nickname_____Child's Birthdate ____/____/____ Age_____

Address_____

City _____ State _____ Zip_____

Does Your Child Play Sports? ❑ Yes ❑ No If Yes, What Sports_____

How did you hear about our Office? (please list name)

❑Pediatrician/Other Dentist_____ ❑Friend _____

❑School/Church/Synagogue_____ ❑Google ❑Yelp ❑Local Newspaper

❑NY Metro Parents Magazine ❑NY Metro Parents Website ❑Other _____

Mother's Information

Name _____ DOB ___/___/____

Occupation _____SS# ____-____-____

Employer (name/address)_____

_____

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

Preferred Method of Contact:

❑Text Message ❑Email ❑Cell Phone ❑Work Phone ❑Home Phone

Father's Information

Name _____ DOB ___/___/____
Occupation _____ SS# ____-____-____
Employer (name/address)_____
_____
Cell Phone _____ Home Phone_____
Work Phone _____ Email _____
Preferred Method of Contact:
❑Text Message ❑Email ❑Cell Phone ❑Work Phone ❑Home Phone

Who is accompanying the child today?
Name _____ Relationship _____
Authorized Nanny/Sitter/Au Pair _____

In the event that I am unable to bring my child in for an appointment the following individuals have my permission to accompany my child and make any necessary decisions for my child's care. This includes consenting to any necessary treatment plan changes.

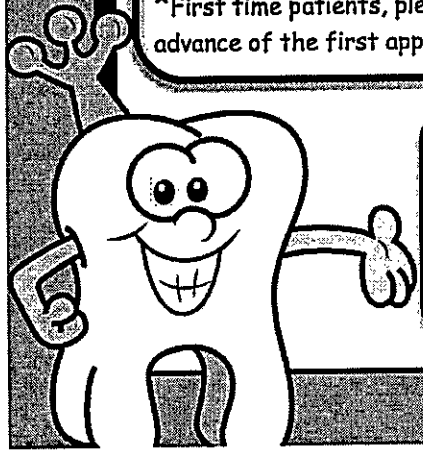
Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

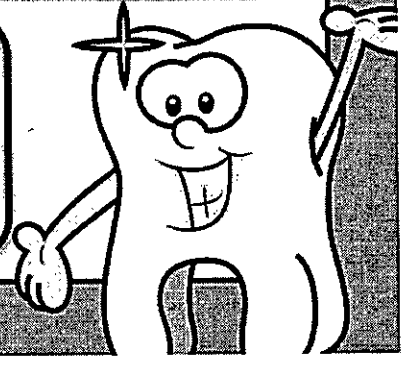
The legal guardian must accompany their child/children for the first appointment.

Insurance/Financial Information

Name of Dental Insurance Company_____
Telephone # of Insurance Company _____
Policy Holder ID # _____ Group # _____
*First time patients, please bring your dental insurance card to the office or email copies of both sides in advance of the first appointment.

Policy Owner's Name_____
Relationship to Patient_____
Policy Owner's Birthdate_____
Social Security #_____
Policy Owner's Employer_____





Health History

Your Child's health is ❑Excellent ❑Fair ❑Poor

Child's Physician _____ Phone # _____

Date of last physical exam ___/___/____

Has your child ever been hospitalized overnight? ❑Yes ❑No

When? _____ Reason for hospitalization_____

Vaccinations up to date? ❑Yes ❑No

History of Surgery? ❑Yes ❑No Type of Surgery_____

Does your child have any allergies to food? ❑Yes ❑No

If yes, please list

_____

_____

Does your child have any allergies to medicine? ❑Yes ❑No

If yes, please list

_____

_____

Has your child ever had any of the following conditions?

❑Asthma	❑Autism Spectrum Disorder	❑ADHD
❑Heart Murmur	❑Congenital Heart Defect	❑Arrhythmia
❑Epilepsy/Seizures	❑Artificial Heart Valve	❑Cancer/Tumors
❑Leukemia	❑Lymphoma	❑Sickle Cell
❑Artificial bones/Joints	❑Recurrent Ear Infections	❑Cleft Lip/Palate
❑Developmental Delay	❑Birth Defects	❑Glaucoma
❑Thyroid Function Issue	❑Cerebral Palsy	❑HIV/AIDS
❑Blood Transfusion	❑Abnormal Bleeding	❑Hemophilia
❑Endocrine Function	❑Issue Fainting/Dizziness	❑Lung Disease
❑Crohn's Disease	❑High/Low Blood Pressure	❑Hearing Loss
❑Ulcerative Colitis	❑Liver/ Hepatitis	❑G6PD
❑Gluten/Celiac Disease	❑Diabetes	❑Anemia
❑Kidney Disease	❑Jaundice	❑Tuberculosis

❑Other not listed_____

Please List ALL medications your child takes, their dosages and frequency

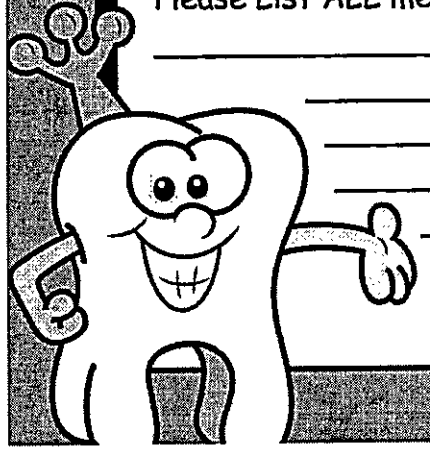
_____

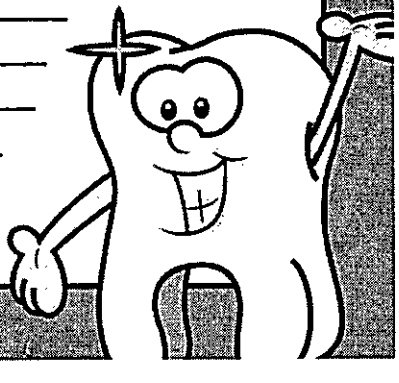
_____

_____

_____

_____





Dental History

Reason for Today's Visit _____

Is this your child's first visit to the dentist? ❑Yes ❑No

If not, who was the previous dentist _____Phone #_____

When was your child's last exam? ___/___/____

When were x-rays taken? ___/___/____

If x-rays were taken, please ask previous office to email records to sayehnaemdds@gmail.com

Has your child had any previous dental injury? ❑Yes ❑No

If yes, when? ___/___/____

Does your child require pre-medication prior to dental treatment? ❑Yes ❑No

Has your child had a history of the following and if so when did they stop:

❑Bedtime Bottle	❑Fluoride Vitamins	❑Pacifier	❑Breast Feeding
❑Iron Supplements	❑Teeth Grinding	❑Bottled Water	❑Mouth Breathing
❑Snoring	❑Thumb Sucking	❑Finger Sucking	❑Fingernail Biting
❑Sleep Apnea	❑ TMJ	❑Other Habits_____	

Age Stopped _____

What Kind of multivitamin does your child use, if any?

❑Chewable ❑Liquid ❑Drops ❑Gummy ❑None

Does your child take a fluoride supplement prescribed by a pediatrician or a previous dentist? ❑Yes ❑No

Do you brush your child's teeth or do they brush independently? _____

Does your child use: ❑Floss/Flossers ❑Fluoride Rinse (ie ACT)

Has your child had any previous negative dental experiences? ❑Yes ❑No

If yes, please explain_____

_____

Please list any additional questions or concerns you may have_____

_____

_____

HIPAA Privacy Practices Notification

I, the undersigned parent/legal guardian of_____, have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my child's medical and health information. I acknowledge that the Practice will use and disclose my child's health information for the purposes of treating my child, obtaining payment for services rendered to my child and conducting health care operations.

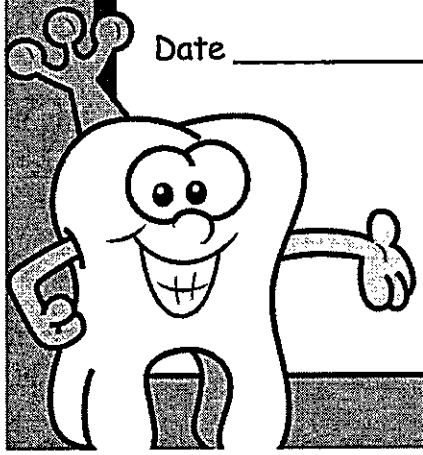
Authorization and Release

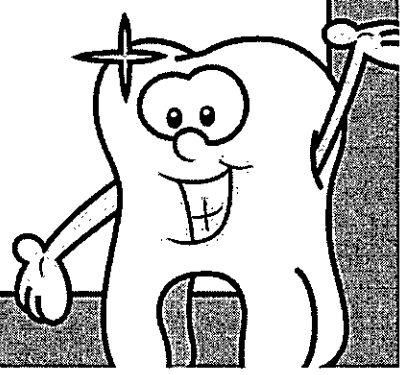
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk. Furthermore, I understand that it is my responsibility to inform this dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners as necessary. I hereby authorize the Dr.Veronica Tadros DMD or any other doctor employed by GLAD Dental to perform the examination and after explanation, any and all treatment for the above named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that, as a condition of my child's treatment by this office, financial arrangements must be made in advance.

Parent/Guardian's Signature _____

Parent/Guardian Name Printed _____

Date _____





GLAD

General & Laser Assisted Dentistry
Dr. Sayeh Naem D.D.S
971 Route 45, Suite 102
Pomona, New York 10970
Phone: (845)362-2200 Fax: (845)362-2291

IMPORTANT POLICY NOTICE REGARDING INSURANCE AND PAYMENT

We will file your insurance as a courtesy to you and will accept "assignment of benefits" on your behalf. Regardless of what we may calculate your insurance company will pay, it is only an estimate. The financial obligation for dental treatment is between you and this office and is not between this office and your insurance company.

We will do all we can to get the maximum benefits reimbursed for you. But please be aware that some of the services provided may not be covered or may be considered above "usual and customary". You are responsible for the payment of your account.

We have flexible payment arrangements but expect those arrangements to be discussed at the time of your visit. We can accept the following payment methods:

Please indicate your preferred method of payment below

_____ Cash

_____ Personal Check

_____ Credit Card (Visa, Mastercard, American Express, Discover)

_____ Automatic Monthly Payments to your credit card

_____ Care Credit (As us about this healthcare credit card with flexible payment plans)

I understand the above payment policy:

X _____

_____ _____

Print Name Date

GLAD DENTAL APPOINTMENT CANCELLATION POLICY

We strive to provide excellent dental care to you and the rest of our patients. To be respectful to our staff and the rest of our patients, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all our patients. We require that you give our office **24 hours' notice if you need to reschedule your appointment. For Monday patient, we require you cancel by Friday if need be.** If you miss an appointment without contacting our office in the provided time, it will be considered a missed appointment; The **dentist fee is $75.00** and will be charged to your account. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred with out the payment of this fee.

Additionally, if a patient is **more than 15 mins late** without prior notice for a scheduled appointment, we will consider this a missed appointment and the appropriate fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your understanding.

I have read and understand the **Appointment Cancellation Policy** of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I_____(print name), agree to the terms of the cancelation policy.

Date_____

COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____ (Print name), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray one way the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

-I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

-Fever

-Shortness of breath

-Dry cough

-Runny nose

-Sore throat

_____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet and that this is not possible in dentistry.

_____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.

-I verify that I have not traveled outside the United States in the last 14 days _____ (Initial)

-I verify that I have not travelled via airline, bus, or train within the last 14 days _____ (Initial)

I have discussed with my dentist the pros and cons of my dental treatment in relation to contracting COVID-19.

I am satisfied that my dentist answered all of my questions.

Although there are no guarantees in regards to the possibility of contracting COVID-19, my dentist and his staff will be following safety protocols as to best protect myself and the staff during treatment. I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time.

Signature: _____ Date: _____

Temperature (taken in office): _____ Time taken: _____