WELCOME! PLEASE TELL US ABOUT YOUR CHILD….

CHILD'S NAME first_____middle_____last_____ **GENDER M F**

NICKNAME/PREFERS TO BE CALLED _____ **BIRTHDATE** _____/_____/_____

ADDRESS street_____city_____state_____zip_____

PHONE ( ) _____ **ALTERNATE1( )** _____ **ALTERNATE2( )** _____

FAMILY'S PRIMARY EMAIL ADDRESS _____@_____

FUTURE APPOINTMENTS MAY BE CONFIRMED VIA E-MAIL. PLEASE INFORM THE STAFF IF YOU DO NOT WISH TO RECEIVE THESE E-MAILS.

WHOM MAY WE THANK FOR YOUR REFERRAL? *INTERNET SEARCH _____ *INSURANCE _____ *YELLOW PAGES_____

***ADVERTISEMENT** _____ ***RELATIVE/FRIEND** _____

***PEDIATRICIAN**_____ ***DENTIST**_____ ***OTHER**_____

PARENT/GUARDIAN INFORMATION

PARENT NAME (MOM/DAD)_____ **PARENT NAME (MOM/DAD)**_____

DATE OF BIRTH _____ **DATE OF BIRTH** _____

SSN _____---_____---_____ **SSN** _____---_____---_____

OCCUPATION_____ **OCCUPATION**_____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE PLAN NAME _____ **INSURANCE PHONE #** _____
SUBSCRIBER'S NAME _____ **RELATIONSHIP TO PATIENT** _____
SUBSCRIBER'S SSN OR MEMBER/POLICY ID # _____ **MEMBER DOB** _____
GROUP # _____ **SUBSCRIBER'S EMPLOYER** _____

PRIMARY DENTAL INSURANCE PLAN NAME _____ **INSURANCE PHONE #** _____
SUBSCRIBER'S NAME _____ **RELATIONSHIP TO PATIENT** _____
SUBSCRIBER'S SSN OR MEMBER/POLICY ID # _____ **MEMBER DOB** _____
GROUP # _____ **SUBSCRIBER'S EMPLOYER** _____

DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? Y / N IF NO, FORMER DENTIST _____
DATE OF LAST DENTAL VISIT _____ REASON? _____
HOW MANY TIMES A DAY IS YOUR CHILD BRUSHING? zero 1x 2x 3x+ DOES HE/SHE FLOSS? Y / N
TAKE FLUORIDE IN ANY OF THESE FORMS: TABLETS/DROPS TOOTHPASTE RINSE/GEL BOTTLED H2O OTHER
HAVE ANY CURRENT COMPLAINT OF DENTAL PAIN? Y/N IF YES, EXPLAIN: _____

DOES YOUR CHILD HAVE A HISTORY OF:
___ THUMB/FINGER SUCKING ___ PACIFIER ___ BOTTLE FEEDING ___ BREASTFEEDING ___ SIPPY CUP
___ SPEECH ISSUES ___ BLEEDING/SORE GUMS ___ MOUTH BREATHING ___ BAD BREATH
___ GRINDING/CLENCHING ____ ABSCESS/INFECTION ____ NAIL BITING ____OTHER _____

MEDICAL HISTORY

PEDIATRICIAN _____ PHONE_____
ADDRESS/TOWN _____ DATE OF LAST PHYSICAL _____
PLEASE LIST MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY Y / N IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE ANY ALLERGIES TO ___PENICILLIN/AMOXICILLIN ___SULFA ___ LATEX ___ OTHER
(PLEASE SPECIFYALL KNOWN ALLERGIES INCLUDING FOODS AND ENVIRONMENTAL ALLERGENS):

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

_ AIDS/HIV	**_ CEREBRAL PALSY**	**_ JAUNDICE (SEVERE)**	**_ SEIZURES**
_ ADHD/ADD	**_ CONVULSIONS/EPILEPSY**	**_ KIDNEY DISEASE**	**_ SINUS PROBLEMS**
_ ANEMIA	**_ DIABETES**	**_ LEARNING DISABILITY**	**_ SPEECH DELAY**
_ ASTHMA	**_ EAR INFECTIONS (CHRONIC)**	**_ LIVER DISEASE**	**_ STOMACH/GI**
_ AUTISM/PDD/SPECTRUM	**_ GENETIC DISORDER**	**_ MEASLES**	**PROBLEMS**
_ BIRTH DEFECT	**_ HEAD INURY**	**_ MONONUCLEOSIS**	**_ TUBERCULOSIS**
_ BLEEDING DISORDER	**_ HEARING DISABILITY**	**_ MUMPS**	**_ TUMOR**
_ BLOOD TRANSFUSION	**_ HEART MURMUR**	**_ PSYCHIATRIC CARE**	**_ VISION PROBLEMS**
_ BONE DISORDER	**_ HEART PROBLEMS**	**_ RADIATION THERAPY**	**_ OTHER (EXPLAIN**
_ BRONCHITIS	**_ HEPATITIS**	**_ RESPIRATORY ISSUES**	**BELOW)**
_ CANCER	**_ HIGH BLOOD PRESSURE**	**_ RHEUMATIC FEVER**	

OTHER _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION ARE TRUE AND CORRECT. IF THERE ARE ANY CHANGES IN MY CHILD'S INFORMATION AND/OR HEALTH STATUS, I WILL INFORM THE DOCTOR AS SOON AS REASONABLY POSSIBLE AND WITHOUT FAIL. I UNDERSTAND THAT THIS INFORMATION WILL REMAIN CONFIDENTIAL

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

SIGNATURE OF DOCTOR _____DATE _____

Pediatric Dentistry of Garden Syosset

General Consent

I hereby give my consent to Stacey Reynolds, DDS and Staff to treat my child which may include the following dental procedures:

complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), study models, photographs, and other diagnostic aids deemed necessary by Dr. Reynolds to make a thorough diagnosis of my child's dental needs.

I authorize Dr. Reynolds to provide any information to other Doctors (Physicians, Dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment by Dr. Reynolds or staff member, that I may ask questions concerning the treatment, and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of my child/the patient.

Parents/Guardians: for future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information:

Name of authorized person(s) to accompany my child for future treatment visits:

1. _____ **Relationship to Child** _____
2. _____ **Relationship to Child** _____
3. _____ **Relationship to Child** _____
4. _____ **Relationship to Child** _____

Parent/Guardian Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Pediatric Dentistry of Garden Syosset

FINANCIAL POLICY

We are delighted to welcome your child to our practice and we are pleased that you have chosen us to serve your child's dental needs. The following is a statement of our financial policy which we require you to read and sign at the bottom of this page.

PAYMENT IS EXPECTED AT THE TIME THAT SERVICES ARE RENDERED
AND IS THE RESPONSIBILITY OF THE ACCOMPANYING ADULT.

Payment methods: we accept all major credit cards, personal checks*, cash.

***All returned checks are subject to a fifty dollar ($50.00) service charge.**

DENTAL INSURANCE

We are in-network providers with Delta Dental. We are considered out-of-network providers with other insurance plans. We are please to accept payment directly from your PPO insurance – please verify with our staff if you are not sure if your insurance provider is included in this policy. What your insurance doesn't pay is the patient/parent's responsibility (you are responsible for the difference in what they pay). We do not participate with any HMO/DMO or Medicaid plans.

An estimated co-payment is requested from you at each appointment as service is rendered. This is determined by your benefits within your plan, not our office.

Please understand that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles their claims or for what benefits they allow on a claim. We can only assist you in estimating your portion of the fees. We cannot guarantee what your insurance will pay for each claim nor can we assume responsibility for the accuracy of any insurance information. It is your responsibility to understand your insurance policy and terms.

You are responsible for payment of any balance due not paid by your insurance company, including unpaid deductible amounts. Although we try our best to estimate as accurately as possible, the final amount your insurance will actually pay is not determined until they issue a claim check to us. If there is an outstanding balance to your account past due 90 days we have the right to send the account to a collection agency and your account balance plus any fees incurred from attempting collection will be owed. Please help us avoid this by paying your portion promptly.

MISSED APPOINTMENTS

We ask for your utmost courtesy regarding your scheduled appointments. If you are unable to keep your child's appointment *please allow at least 24 hours* prior to the appointment time if you must cancel or reschedule. We understand that unforeseen emergencies do occur, however, we reserve the right to charge a $50.00 fee for repeated last minute cancellations and broken appointments.

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THIS POLICY.

Parent's Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 5, 2009, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our notice in our office and on our website pdofgc.com. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 585 Stewart Avenue #LL60, Garden City, NY 11530.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 585 Stewart Avenue #LL60, Garden City, NY 11530. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 585 Stewart Avenue #LL60, Garden City, NY 11530.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 585 Stewart Avenue #LL60, Garden City, NY 11530. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer – Stacey Reynolds, DDS
585 Stewart Avenue #LL60
Garden City, NY 11530
Telephone: 516.222.5100
Email: pdofgc@gmail.com