ISLAND
PEDIATRIC DENTISTRY

ABOUT YOUR CHILD

Name _____

Nick Name _____

( )Female ( )Male

Birthdate _____

School _____

Home Address

_____

_____

DENTAL INSURANCE INFORMATION

Name _____

Employer Name _____

Policy Holder Name _____

Policy Holder Birthdate _____

Policy Number _____

Social Security Number

_____

PARENT #1 (MOTHER) INFORMATION

Name _____

Home Address ( ) same as child

_____

_____

Home Phone _____

Cell Phone _____

Email _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Family _____

Friend _____

Online _____

Other _____

PARENT #2 (FATHER) INFORMATION

Name _____

Home Address ( ) same as child

_____

_____

Home Phone _____

Cell Phone _____

Email _____

ANY OTHER INFORMATION YOU'D LIKE TO SHARE.

DENTAL HISTORY

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

If not, when was the last visit?

_____

Previous dentist's name

_____

In the past, have there been any injuries to the teeth, mouth or face? ( ) No

_____

_____

Why did you bring your child to the dentist today?

_____

_____

Has the child ever had problems associated with previous dental work? ( ) No

( ) Medical complication _____

( ) Behavioral issues _____

_____

The following answers will help us better serve our patients. Thank you.

Child brushes twice a day with fluoride Toothpaste under supervision.	Yes	No
Child flosses daily under supervision.	Yes	No
Child drinks fluoridated water or/and takes fluoride supplements such as rinse or pills.	Yes	No
Child has regular dental care.	Yes	No
Child experienced cavities before.	Yes	No
Child has more than 3 snacks a day.	Yes	No
Child goes to bed with a bottle containing other than water.	Yes	No
Child has special healthcare needs.	Yes	No
Family member has active cavities.	Yes	No

MEDICAL HISTORY

Has your child ever had any of the following conditions?

Allergies to drugs	Yes	No
Allergies to food	Yes	No
Hospitalization	Yes	No
Surgeries/Operations	Yes	No
Cancer	Yes	No
Asthma	Yes	No
Congenital birth defects	Yes	No
Epilepsy/Convulsions	Yes	No
Tuberculosis	Yes	No
Pregnancy	Yes	No
ADD/ADHD	Yes	No
Autism spectrum disorder	Yes	No
Special needs	Yes	No
Hearing impairment	Yes	No
Heart disease/Murmur	Yes	No
Hemophilia/Blood disorders	Yes	No
Hepatitis	Yes	No
HIV+/AIDS	Yes	No
Kidney Condition	Yes	No
Liver Condition	Yes	No
Rheumatic/Scarlet fever	Yes	No
Allergic reaction to latex	Yes	No
Diabetes	Yes	No
Need for prophylactic antibiotics	Yes	No
Emotional conditions	Yes	No

Please list any other medical Conditions the child may have. ( ) None

_____

_____

Please list drugs the child is taking.

_____

_____

Child's physician _____

Physician Phone _____

Please describe the child's current Health condition.

( ) Good ( ) Fair ( ) Poor

I certify that the information I have given is correct to the best of my knowledge. I understand that it will held in the strictest of confidence and it is my responsibility to inform this office any changes. I authorize the dental staff to perform necessary dental services my child may need.

Parent/Guardian Signature date relationship to patient

Insurance & Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide you with payment information in advance to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Your dental insurance benefits are based upon a contract made between your employer and the insurance company. Dental benefit plans rarely pay 100% of dental care. It is only mean to assist you partially. If you have any questions regarding the terms of your benefit, please contact your HR department or the insurance company directly.

We accept many insurance plans. This means we literally work with thousands of companies. Although we maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we recommend filing a "pre-treatment authorization" prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket expense.

Your deductibles and co-payments are expected to be paid in full (cash or credit card) at the time of service. We do not bill patients after treatment is completed to avoid additional paperwork or delinquency.

I have received, read and agree to the above financial policy.

_____

Parent/Guardian Name Signature Date

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide. We understand that any dentist can get your child's work done; our mission is to do so in a manner, which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of child patients by the use of warmth, friendliness, persuasion, humor, gentleness, kindness, and understanding. There are several behavior management techniques that are used to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are not a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully & ask about anything you do not understand.

The following are everyday-use-techniques that work well with children who are willing to listen and follow directions.

1. Tell-show-do: The doctor or assistant tells the child what is to be done using simple terminology and then shows the child what is to be done by demonstrating with instruments outside child's mouth first. Then the procedure is performed in the child's mouth as described.
2. Positive reinforcement: This technique rewards the child who displays desirable behavior. Rewards include compliments, praise or a prize.
3. Negative reinforcement: Similar to positive reinforcement in many ways but the child will lose privileges if uncooperative. He/she is then promised to re-gain the lost lost privileges back upon improving his/her behavior.
4. Voice control: is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
5. Mouth prop/rubber dam/Isolite: A mouth prop or "tooth pillow" as we call it is used to help support your child in keeping his/her mouth open during a procedure. This allows him/her to relax and not worry about keeping his/her mouth open for the procedure. A rubber dam or Isolite is an "umbrella/vacuum" placed on the area of mouth to be worked on to isolate the teeth and prevents any debris from being swallowed or going to the back of the throat.
6. Movement stabilization by the doctor: The doctor controls the child's movement by gently holding down the child's head or upper body.
7. Movement stabilization by the assistant: The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements.
8. Laughing gas: Nitrous oxide and oxygen is used to relax the child and to raise his/her pain threshold. This allows the child to sit in chair longer and increases their attention span and allows for more work to be done efficiently. Nitrous oxide is NOT general anesthesia. The child does not fall asleep or becomes unconscious.

The following technique is available for children who cannot/won't listen and follow directions voluntarily. This technique will be utilized **ONLY** after obtaining the **PARENT'S CONSENT**.

9. Immobilization by papoose wrap: A restraint device, designed specifically for pediatric procedures, is used when immobilization is needed for the safety of the patient and the dental team. It is mostly used during emergency procedures.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. I hereby acknowledge that I have read and understand this consent.
2. I was given a chance to ask any questions or express any concerns I have.
3. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in pediatric dentistry and used to provide the best dental care.
4. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the option to withdraw from it.
5. I hereby authorize Island Pediatric Dentistry Team to utilize the necessary techniques to assist in the provision of the required dental treatment for my child.
6. I understand that this consent shall remain in effect until terminated by me.

_____

Patient Name Person Authorized to Consent Relationship To Patient 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.

OUR LEGAL DUTY

We are required by applicable federal and state 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 April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to 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. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

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 us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We 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 a physician, dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this notice.)

Disclosure Accounting: 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, healthcare operations and certain other

activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), 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, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: Sara Seo
Telephone: 516-437-6000
Address: 1300 Union Tpke, Suite 307, New Hyde Park, NY 11040

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name Date

_____ _____

Parent/Guardian Name Signature

For Office Use Only

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

APPOINTMENT POLICY

Promises are important to keep. We teach our children to honor their promises. When we make appointments, we are making promises to be available for each other at a given date & time. When you do not show up for your scheduled appointments or cancel last minute, it not only costs the doctor's time but it also costs other patient's time as well. That wasted appointment time could have been given to someone else who really needed the service.

We are a pediatric practice. It means that we basically see patients only for 3 hours a day once schools finish. We do not have much time to waste.

We want to inform you that there will be a $50 charge if you miss your appointment without a 48-hour notice. We do understand that things come up and you are unable to keep your appointment sometimes. We are simply asking to give us a quick call/text/email as early as possible so that we can serve other patients instead.

We pride ourselves in running a very efficient office where everyone's time is valued. We try our best to accommodate all appointment requests but we need your help in doing that. Thank you for understanding and we hope this will improve our appointment efficiency.

I was informed of the appointment policy and I understand it.

_____

Patient Name Guardian Name Signature Date