ISLAND PEDIATRIC DENTISTRY

516.437.6000

~WELCOME~

1300 Union Tpke, Suite 307, New Hyde Park, NY 11040
www.islandpediatricdentistry.com

ABOUT YOUR CHILD

Name _____
Nick Name _____
( ) Female ( ) Male
Date of Birth _____
Siblings That We Treat:
_____
School _____
Grade _____
Home Address
_____
_____
Home Phone _____

MOTHER'S INFORMATION

Name _____
Home Address ( ) same as child
_____
_____
Home Phone _____
Work Phone _____
Cell Phone _____
Email _____
Best Way to Contact
( ) Phone call ( ) Text ( ) Email

FATHER'S INFORMATION

Name _____
Home Address ( ) same as child
_____
_____
Home Phone _____
Work Phone _____
Cell Phone _____
Email _____
Best Way to Contact
( ) Phone call ( ) Text ( ) Email

PERSON RESPONSIBLE FOR THE ACCOUNT

Name _____
Relationship _____
Billing Address ( ) same as child
_____
_____
Home Phone _____
Work Phone _____
Cell Phone _____
Email _____
Best Way to Contact
( ) Phone call ( ) Text ( ) Email

PRIMARY DENTAL INSURANCE

Insurance Company Name
_____
Group Number _____
Policy Owner's Name
_____
Relationship to Patient _____
Policy Owner's Birthdate _____
Social Security Number _____
Employer's Name _____

SECONDARY DENTAL INSURANCE

Insurance Company Name
_____
Group Number _____
Policy Owner's Name
_____
Relationship to Patient _____
Policy Owner's Birthdate _____
Social Security Number _____
Employer's Name _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Family _____
Friend _____
Website _____
Other _____

ANY IMPORTANT INFORMATION

DENTAL HISTORY

Is this your child's first visit to the dentist? _____

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?

_____

_____

_____

Why did you bring your child to the dentist today? _____

_____

Has the child ever had problems associated with previous dental work? _____

_____

_____

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

- Parents/caregiver has active cavities. 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
- Child drinks fluoridated water or/and takes fluoride supplements such as rinse or pills. Yes No
- Child brushes twice a day with fluoride toothpaste. Yes No
- Child receives fluoride treatment at dentist. Yes No
- Child has regular dental care. Yes No
- Child experienced cavities before. Yes No

MEDICAL HISTORY

Has the 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. _____

_____

_____

Please list all drugs the child is taking.

_____

_____

_____

Child's physician _____

Physician Phone _____

Please describe the child's current health.

( ) Good ( ) Fair ( ) Poor

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

Parent/guardian Signature Date Relationship to patient

Reviewing Staff 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 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

*You May Refuse To Sign This Acknowledgement

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)