Pediatric Dentistry
400 Kinderkamack Road
Oradell, NJ 07649
Tel: 201-262-0211 Fax: 201-262-0231

PLEASE LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE. LIST MULTIPLE SOURCES IF APPLICABLE:
DOCTOR PATIENT PAPER/MAGAZINE DRIVE BY GOOGLE KEYWORD _______________
NAME OF REFERENCE: ____

PATIENT INFORMATION

Name: ____ Birth date: ______________________
Age: ______ Sex: M____ F ____ E-Mail: ____
Address: ____
City: ____State: ________ Zip: ____________
Home Phone: (_____)______________ Work: (_____)_______________Cell: (____)________________
If Patient is a Student, Name of School: ____
Person to contact in case of emergency:
Name: ________________ Relationship to patient: ___________Phone Number: (____)_____________

RESPONSIBLE PARTY

Name:_____________________________________ Relationship to patient:______________________
Birth Date:_____________Social Security #:__________________ E-Mail: _____________________
Address: ________________________________ City:______________ State:______ Zip: ___________
Home Phone: (_____)___________ Work: (_____)_______________ Cell: (_____)_________________

Check the Appropriate Box: Single **[ ]** Married **[ ]** Divorced **[ ]** Widowed **[ ]** Separated **[ ]**
Drivers License Number: _________________________________ State: _________ Exp: __________

INSURANCE INFORMATION

If you wish to have our office submit your dental claims for you, please fill this section out **completely.**

Primary Dental Insurance

Name of Policy Holder: ___________________________ Relationship to Patient:___________________
Birth Date: __________________ Social Security Number/ ID Number: ___________________________
Employer: ____ Work Phone: (_____)________________
Insurance Company:____________________________________ Group Number:___________________
Address: _______________________________ City:_________________ State:______ Zip:_________
Phone: (_______)_____________________

Secondary Dental Insurance

Name of Policy Holder: ___________________________ Relationship to Patient: __________________
Birth Date: __________________ Social Security Number/ ID Number: ___________________________
Employer: ____ Work Phone: (_____)________________
Insurance Company:____________________________________ Group Number: __________________
Address: ________________________________ City: ________________ State: _____ Zip: _________
Phone: (_______)_____________________

Signature: ____ Date:___________________

DENTAL HISTORY

Reason for today's visit: ________________________________ Date of last dental visit: _____________

Former/Current Dentist: __________________________ Date of last dental X-rays: _________________

Address: ____ City: _____________________ State: _____

Zip Code: ____________ Phone: (_____) _______-________

Is the patient experiencing any of the following:

__ Bad breath
__ Grinding teeth
__ Bleeding Gums
__ Food collection between teeth
__ Loose teeth or broken fillings
__ Clicking or popping jaw
__ Periodontal treatment
__ Sores or growths in mouth
__ Sensitivity when biting
__ Sensitivity to cold
__ Sensitivity to heat
__ Sensitivity to sweets

MEDICAL HISTORY

Physician's Name: _____________________________ Phone Number: (______)___________________
Address: ______________________________ City: ____________ State: _____ Zip Code: __________
Date of Last Visit: _______ Has patient ever had any serious illnesses or operations? **Yes** _____**No** ____
If yes, describe type and date: ____

Check if the patient has had any of the following: (If none, indicate here) NONE _________ (Initials)

__ ADD/ ADHD
__ AIDS/ HIV
__ ANEMIA
__ ASTHMA
__ AUTISTIC
__ CANCER
__ CEREBRAL PALSY
__ CHICKEN POX
__ DIABETES
__ EPILEPSY/SEIZURES
__ EYE DISORDERS
__ EXTREME NERVOUSNESS
__ HEARING PROBLEMS
__ HEART AILMENTS
__ HEMOPHILIA
__ TONSILLITIS
__ HEMOPHILIA
__ HEPATITIS
__ HIVES
__ KIDNEY PROBLEMS
__ LEARNING DISABILITY
__ LIVER PROBLEMS
__ MEASLES
__ ULCER OR COLITIS
__ INTELLECTUAL DISABILITY
__ MONONUCLEOSIS
__ RHEUMATIC FEVER
__ PSYCHIATRIC CARE
__ SINUS PROBLEMS
__ PHYSICALLY HANDICAP
__ THYROID DISORDER
__ OTHER:

Medications: (list medications patient is taking and correlating diagnosis):

____

Allergies:

____

____

Does your child take vitamins with Fluoride? **Yes** ____ **No** ____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my/ the patients health.

Signature: ________________________ Relationship: ___________________ Date: ______________

*Reviewed by Doctor: ____ 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

Print name: ____ Date: _________________________

Signature: ____ Date: _________________________

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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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

Authorization Form for Release of Protection Health Information

Patient(s) Name	Date of Birth
_________________________________	_________________________________
_________________________________	_________________________________
_________________________________	_________________________________

I hereby authorize the use and disclosure of individually identifiable dental health information relating to the above named patient (s) as described below. I understand that information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Person(s) Receiving Patient's Authorized Information Include:

____

____

I understand that I may revoke this authorization at any time by notifying Kindersmiles in writing. If I choose to do so, my revocation will not affect any actions taken by Kindersmiles before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, and enrollment in health plan, or eligibility for benefits.

____ ________________________________

Signature of Patient of Patient's Personal Representative Date

If Personal Representative:_____________________________ Relationship to Patient: _____________

Print Name

Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our patient information sheets before seeing the doctor.

Unless previous arrangements have been made, all payments and co-payments are due at the time of the appointment. Payment may be made by cash, check, MasterCard, Visa, Discover, American Express or prior approval from a third party financing provider (our office participates with Chase Health Advance).

Dental Benefits:

We are pleased that many of you have dental benefits and our office will assist you in obtaining the maximum benefits specified in your contract. However, your benefits are a contract between you and your insurance carrier.

We will assist you in determining your benefits as best as we can because plans differ from carrier to carrier and policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan.

Our practice is committed to providing the highest quality of treatment to our patients and we charge what is usual and customary for our area. We know how confusing insurance plans can= be. If you have any questions, feel free to ask us. We may be able to help you.

For Pediatric Dentistry:

1. Our office is presently an In-Network provider with: Delta Dental (premier plan) and Horizon Blue Cross Blue Shield of NJ (Traditional Plan)
We are **Out-Of-Network f**or every other carrier and plan. If your plan allows you Out-Of-Network benefits, we will gladly accept payments from your insurance carrier. You will be responsible for any balances not covered by your insurance company.

2. Co-payments quoted at the time of service are an estimate and the actual payment due may differ after your insurance carrier has paid their share of your bill. Any balance remaining after your insurance company's payment will be your responsibility.

3. Balances with benefit claims outstanding more than 60 days may be reverted back to the patient.

4. Not all services are a covered benefit in all contracts. Some carriers and employers select only some services to be covered. You are responsible for payment of all services regardless of the payable benefit.

Additional Fees

Returned Check Fee:
Our bank charges us a fee for any check that is returned for “insufficient funds” and a $35.00 fee will be added to the patient’s bill if this occurs.

Ages Accounts:
In the event that your account becomes delinquent for more than 60 days, you agree to pay a finance charge of 1.5% per month on any balance due, as well as reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

Appointment Policy:
We respect your time and ask that you respect ours by honoring your appointment commitment. A broken appointment is a loss to everyone. Remember, once you have made an appointment, this time is reserved for you. Please give us at least 24 hours notice if you are unable to keep your appointment. This will allow us to accommodate the needs of other patients more readily. If we do not receive a cancellation notice within 24 hours, a cancellation fee of $50 per patient ($100 per family) may be applied to your account.

Responsible Party:
For patients under the age of 18, the responsible party is the parent/guardian who accompanies the patients and completes the paperwork. This may or may not be the parent under whom the child is insured. Court documentation may be required in cases of divorce/separation to determine the financially responsible parent/guardian.

I have read the above KinderSmiles Financial Policy. By my signature I acknowledge that I understand and agree abide by its terms.

Print Name: ________________________________ Date: ______________________
Signature of Responsible Party:____

Circle Relationship: SELF PARENT LEGAL GUARDIAN

Signature on File for Dental Insurance

☐ I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.

☐ I authorize release of any information relating to my dental claims

____ ________________________
Signed (Patient OR Insured Parent/Guardian) Date

☐ I assign dental benefit payments to be paid directly to KinderSmiles from my insurance company.

____ ________________________
Signed (Patient OR Insured Parent/Guardian) Date

Consent for Treatment

This is verification that I have brought my child for dental examination and treatment. I hereby consent to have all doctors and associates of KinderSmiles perform dental examinations, cleanings, fluoride treatments, dental restorations [including, but not limited to, tooth colored fillings, silver fillings, and stainless steel crowns, dental x-rays (when necessary), dental extractions and any other procedures deemed necessary or advisable as a corollary to the planned procedures. I further agree to the use of local anesthetic agents, oral and intra-venous sedation agents depending upon the doctor(s) involved in my care.

I understand that there are techniques in pediatric dentistry, which are signed to manage behavior. These techniques may include: excluding a parent from the room on occasion, raising and lowering the doctors voice to aid in communication, mild restraint by a parent, assistant, or doctor and/or similar techniques. I understand that these techniques will be utilized as means of ensuring a safe, productive dental experience for my child.

I have been informed and understand that most dental procedures can be accomplished without complication. There are, however, possible risks inherent in dental procedures, these risks include: post operative pain, infection, swelling, bleeding and/or injury to adjacent soft tissue.

I also understand that it may be necessary, in the best judgment of the doctor to alter any planned treatment. I understand that all payment is due at the time of the procedure.

I hereby give my free and voluntary consent for the treatment to be rendered.

______________________________	______________________________
Last Name (Print)	First Name(s) of All Children Being Treated (Print)
______________________________	______________________________
Signature of Patient, Parent or Guardian	Signature of Doctor
______________________________	______________________________
Witness	Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS 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 protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning you protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 9/1/11, and will remain in effect until we replace it.
We reserve the right to change our privacy practice 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 received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and provide the new notice at our practice location, and we will distribute it 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
Your Authorization: In addition to our use of you health information for the following purposes, 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 writing it at any time. Your revocation will not affect any use or disclosures permitted by your health information for any reason except those described in the notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.
Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment for you.
Payment: We may use and disclose your health information to obtain payment for services we provide for you. For example, we may send claims to your dental health plan containing certain health information.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner an provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: 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 your personal representative, but only if you agree that we may due 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 personal 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 absence or incapacity or in 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.
Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.
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.
Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings. For certain law enforcement purposes; to avert a serious threat or health or safety; and to comply with workers' compensation or similar programs.
Decedents: We may disclose health information about a decedent as authorized or required by law.
National Security: We may disclose to military authorities the heath information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody the protected health information of an 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, postcards, or letters)
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 sending us a letter to the address at the end of this notice. We will charge you a $0.__ for each page, $0.__ per hour for staff time to copy you health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by electronic mail (e-mail.)

Questions and Complaints

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

Telephone: _______________________ Fax: _____________________

E-mail: ____