



PATIENT REGISTRATION

Huntington Smiles Pediatric Dentistry

Patient Name: _____ Last Name: _____
Name Child Would Like to Be Called: _____ Date of Birth: _____
Address: _____ Town, State, Zip _____
Phone Number: _____ Parent's Cell Number: _____
Is anyone in your family currently a patient within our practice? _____
Whom may we thank for your referral or how did you find us? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____
Billing Address (if different from above): _____
Responsible Phone #: _____ Responsible SS#: _____
Date of Birth of Responsible Party: _____

***Please be aware that the person who brings the child is ultimately responsible for consent and final payment. We understand that some of our patients have legal agreements with a former spouse, etc. If this is your case, then you must bring in a notarized letter as such or you will be responsible. ***

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship: _____
Birthdate: _____ SS#: _____ ID #: _____
Name of employer: _____ Union/Local #: _____
Address of employer: _____
City: _____ State: _____ Zip code: _____
Insurance Company: _____ Group Number: _____

Secondary Insurance Company (if applicable): _____ ID #: _____
Name of Insured: _____ Relationship: _____
Birthdate: _____ SS#: _____ - _____

DENTAL INFORMATION

1. Is the patient having any discomfort at this time? Yes No
2. Has the patient ever had any serious trouble with previous dental treatment? Yes No
a. If so, explain _____
3. Does dental treatment make your child nervous? No Slightly Moderately Extremely
4. Is this the patient's first dental visit? Yes No

5. Date of last dental visit _____ Name of previous dentist _____
6. Does your child do any of the following? Brush in the am pm Both
 Use Fluoride Toothpaste Non-Fluoride Toothpaste Take vitamins with Fluoride? Yes No
7. Any current habits? Thumb sucker Finger sucker Pacifier Tongue Thrust Other

MEDICAL INFORMATION

Pediatrician's Name: _____ Phone Number: _____

Is your child under a physician's care now? Yes No

Has your child ever been in the NICU Hospitalized Had a major operation _____

Is your child taking any medications, pills, or drugs? Yes No If so, what are they? _____

Does your child have ADD ADHD PDD Autism Autism Spectrum Disorder?

Is your child on a special diet? Gluten Free No red dye Other _____

Any allergies to medication or foods. If yes, please explain: _____

Does the patient have, or has had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Parathyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Radiation Treatments
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Congenital/Heart Disorder	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mitral Valve Prolapse	

Has the patient ever had any serious illness not listed above? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers are true and correct. If there are ever any changes in my (or my child's) health or changes in medication, I will inform the dentist, hygienist, or the dental office.

Name of Patient _____ Signature of Legal Guardian X _____

Relationship to Patient: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Policy Number 14A

Effective date of Notice: October 1,2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW WE PROTECT YOUR HEALTH INFORMATION, WHAT RIGHTS YOU HAVE REGARDING IT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition related health care services.

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other reuse required by law.

Treatment, Payment, and Health Care Operations

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services.

This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a dental facility providing care for you. For example, your protected health information may be provided when referring you to another dentist for specialty care to ensure that the dentist has the necessary information to diagnose and treat you.

Examples of how we use or disclose information for treatment purposes are: setting up appointments for you; examining your teeth, mouth, and oral health, prescribing medications and requesting them to be filled; prescribing dental appliances; showing you treatment options; getting copies of your health information from another professional that you may have seen before us.

Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).

Complaints

If you think that we have not properly respected the privacy of your health information, you may complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. **We will not retaliate against you for filing a complaint.** If you want to complain to us, send a written complaint to the office via mail, fax, or E Mail. If you prefer, you can discuss your complaint in person or by phone.

For More Information

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Name of Patient _____ Signature of Patient (or Legal Guardian) **X** _____

Relationship to Patient: _____ Date: _____

FINANCIAL POLICY AND CONSENT

I request and authorize Dr. Sarah Chicosky and Dr. Maryam Qayumi-Hussain at Huntington Smiles Pediatric Dentistry and staff under their direction to perform treatment for my child, as necessary. I understand that any treatment needs will be explained to me prior to treatment and will require my consent.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies. This consent will remain in effect unless canceled in writing.

I will notify this office of any changes in my child's health, including current medications, allergies, and any hospital stays.

I authorize Huntington Smiles Pediatric Dentistry to release any information necessary for the processing of dental insurance claims and authorize payment directly to Huntington Smiles Pediatric Dentistry of insurance benefits otherwise payable to me.

I acknowledge that I have read and agree with the office financial policy. **I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment.** I understand that this office bills my insurance as a courtesy and that I am ultimately responsible for knowing the coverages and limitations of my plan. I understand that other changes such as (but not limited to) nitrous oxide inhalation (laughing gas) and fluoride treatment may not be covered by my insurance and will be my financial responsibility.

Initial: _____

I acknowledge that I have given the correct insurance information to the office and will notify the office of any changes in my insurance carrier at least 48 hours prior to all dental appointments. In the event I fail to notify the office within 48 hours, I am aware of my responsibility for payment in full.

Initial: _____

I acknowledge that payment in full is expected in case of no insurance coverage unless prior financial arrangements have been made.

Initial: _____

I agree that any balances over 60 days will be subject to a bill sent to my address on file. Please note that we reserve the right to charge a \$25 fee per child for all missed or broken appointments when not given a 24-hour notice. Repeat missed appointments or lateness without notification will result in dismissal from the practice.

Initial: _____

Child(ren)'s Name(s): _____

Name of Responsible Party/Guardian: _____

Signature: _____ Date: _____

This consent will remain in effect unless canceled in writing. No treatment can be rendered unless you have read and signed this form.