Welcome To Our Practice!

Child s Information

Last Name: ____________________ MI: __________
First Name: ____________________ Nickname: __________
Street: ____________________ City: __________
State: ________ Zip: ________ Phone: __________
Date of Birth: ____________________ Sex: M ❑ F ❑
Referred By: ____________________

Rockland Pediatric Dental, P.C. &
Rockland Dental Group, P.C.

238 North Main Street
New City, NY 10956
(845) 634-8900

Parent/Guardian (Primary Insurance Holder)

Title: Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑
Last Name: ____________________
First Name: ____________________ MI: __________
Social Security #: ____________________ Sex: M ❑ F ❑
Date of Birth: ____________________ Age: __________

Address Of Parent/Guardian (Primary Ins. Holder)

Street: ____________________
City: ____________________
State: ____________________ Zip: __________
Home Tel #: ____________________
Relationship to Patient: ____________________

Employer [Of Parent/Guardian (Primary Ins. Holder)]

Name: ____________________
Business Tel #: ____________________ Ext #: ________
Group #: ____________________
Address: ____________________
____
____

Insurance

❑ DMO ❑ PPO ❑ Co-Pay $ ________
Name: ____________________
Policy #: ____________________
Group #: ____________________
Address: ____________________
____
Tel #: ____________________

MEDICAL HISTORY

Name of physician or pediatrician ____________________

Address and Phone Number ____________________

Date of last physical examination __________ General Health: Excellent ______ Good ______ Fair ______ Poor ______

Is child under physician s care at present? ______ If yes, explain: ____________________

Is your child taking any medications? ______ Special diets? ______ If yes, please list: ____________________

Is your child allergic to any drugs, i.e. penicillin? ______ If yes, name: ____________________

Does your child have any allergies, i.e. eggs, latex? ______ Please list: ____________________

Has your child ever been hospitalized? ______ If yes, explain: ____________________

Is your child excessively nervous or apprehensive? ____________________

Has your child s development been normal? ______ Was pregnancy normal? ______ Was delivery normal? ______

Early feeding habits: Breast fed? ______ Bottle fed? ______ Formula used? ______ Type of nipple used? ______

Was a pacifier used? ______ Started and stopped at what age? ______ to ______

Child s appetite is: Excellent ______ Good ______ Fair ______ Poor ______

Child s sleep habits: Excellent ______ Good ______ Fair ______ Poor ______

	HAS YOUR CHILD HAD OR CURRENTLY HAVE......	Yes	No	NOTES		HAS YOUR CHILD HAD OR CURRENTLY HAVE......	Yes	No	NOTES		HAS YOUR CHILD HAD OR CURRENTLY HAVE......	Yes	No	NOTES
1	Rheumatic Fever?				12	**Coordination Disorder?**				23	Rheumatoid Arthritis?			
2	**Heart Murmur?**				13	Hepatitis?				24	**Stomach/Intestinal Disorders?**			
3	Congenital Heart Problems?				14	**Jaundice?**				25	Blood Disorder?			
4	**Other Cardiac Disease?**				15	Liver/Kidney Disorder?				26	**Nervous/Neurological Disorders?**			
5	Anemia?				16	**Tuberculosis?**				27	Muscular Disorder?			
6	**Asthma?**				17	HIV Positive?				28	**Staphylococcal Infections?**			
7	Respiratory Problems?				18	**Hives/Skin Disorder?**				29	Hyperactivity?			
8	**Unusual Bleeding/Blood Disorder?**				19	Thyroid/Glandular Problems?				30	**Learning Disability?**			
9	Diabetes?				20	**Ear/Hearing Problems?**				31	Early Intervention?			
10	**Seizures?**				21	Visual (eye) Disorder?								
11	Dizziness/Fainting?				22	**Tumors?**								

Other childhood illnesses/diseases that your child has had ____________________

Are vaccinations up to date? ____________________

DENTAL HISTORY

Reason for this visit? (First examination, check-up, toothache, etc.) ____________________

____

Do you desire complete, thorough dental care for your child?__________

Was your child s last dental experience pleasant?________ If unpleasant, how did he/she react?__________

____

Did teeth erupt early or late?__________ At what age?__________

Is your child taking fluoride tablets or drops?__________ Vitamins?__________ By Prescription?__________

When was your child s last dental visit?__________

When were your child s last dental x-rays taken?__________

Has your child ever had: ❑ Dental X-rays ❑ Cleaning ❑ Fillings ❑ Fluoride treatment ❑ Pulpotomy/root canal ❑ Stainless steel crowns ❑ Extractions ❑ Surgery ❑ Gas (sweet air) ❑ Local anesthesia (Lidocaine) ❑ Space maintainer ❑ Orthodontic appliance ❑ Sealants

Does your child have: ❑ Trauma or injuries to teeth or face ❑ Sensitive teeth ❑ Bleeding or sore gums ❑ Unusual speech habits ❑ Missing teeth ❑ Many cavities ❑ Growth or sore spots in or around the mouth ❑ Extra teeth

Does your child: ❑ Grind teeth (if yes, when?)__________ ❑ Suck thumb or finger ❑ Bite lip or other biting habits ❑ Mouth breather

Have you ever been counseled on proper diet?__________ Instructed in proper home care of the mouth?__________

How often does your child brush his/her teeth?__________ Do you assist?________ Type of brush?__________

Other oral hygiene aids ____________________

What do you believe is the cause for tooth decay in anyone?

❑ Soft Teeth/Heredity ❑ Excessive Sweets ❑ Toothbrushing Habits ❑ Other__________

I certify that the medical information above is accurate to the best of my knowledge. I further agree to notify Rockland Pediatric Dental, P.C. & Rockland Dental Group, P.C. about any additions or changes in my child's overall condition.

Signature of Parent/Guardian ____________________ Date __________

Reviewed By ____________________

Rockland Pediatric Dental, P.C. & Rockland Dental Group, P.C.

INSURANCE DISCLAIMER

The patient is responsible for understanding his/her insurance in regards to policy, procedures, prior authorization, referrals, maximums and general coverage guidelines. Our office works hard to ensure hassle-free billing and insurance transactions, and given the numerous benefit packages that are provided through each policy, it is still the patient's responsibility to be properly informed on coverage benefits.

☐ Patient Dental Insurance Consent Agreement   Initials________

Your dental care is important. Your insurance benefits greatly help. This is how they work together.

1. Every insurance policy is different. We will help you explain the benefits you have with your individual plan. It is up to you to call your insurance company and learn exactly what benefits you have and what you don't have.
2. As a participating provider, we have agreed to accept Delta Dental PPO, Guardian PPO, MetLife PPO, Principal PPO, United Concordia, DenteMax, Cigna PPO and the Dental Health Alliance (Aetna PPO). We will file the insurance claim on your behalf. However, you are responsible for the patient portion. Any remaining fees or any service not covered by your insurance plan is 100% your responsibility. All proposed treatment will be discussed with you in detail prior to commencing work.
A pre-determination may be requested and submitted to the insurance company on your behalf for preliminary review of proposed treatment. This review can take anywhere from 2-4 weeks. This is only an ESTIMATE. It is only when the actual dental claim is submitted and reviewed that payment is determined.
Your level of insurance coverage is determined by the policy your employer selects. If you think your coverage is insufficient, you should address this with your employer.
If the insurance pays less than expected, we will send you a statement for the remaining balance, which is payable on receipt. Balances not paid within 60 days are subject to a finance charge.
Our office accepts all major credit cards, checks and cash. Financing is available through CareCredit with proper approval. A pre-payment courtesy is available for cases over $500.

☐ Divorced/Separated Parents of Minor Patients: Initials________

The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Rockland Pediatric Dental, P.C. & Rockland Dental Group, P.C. will not be involved with separation or divorce disputes.

Your time is valuable, as is ours. We reserve the right to charge $50-$100 for appointments broken or cancelled without 24 hours advance notice. I have read and understand the financial policies for Rockland Pediatric Dental, P.C. & Rockland Dental Group, P.C. and agree to the terms stated above.

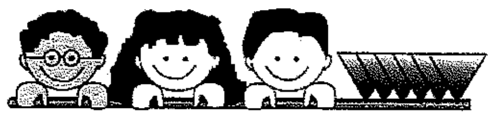
Signature____ Date__________________

Print Name____

AUTHORIZATION

I authorize Rockland Pediatric Dental, P.C. & Rockland Dental Group, P.C. to perform an oral examination for the purpose of diagnosis and treatment planning on my child. In addition, if medically necessary, I authorize th release of any information acquired in the course of this examination and treatment.

Signature of Parent/Guardian________________________________ Date__________



Rockland Pediatric Dental, P.C. & Rockland Dental Group, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*** You May Refuse To Sign This Acknowledgement ***

Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually unidentifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information issued. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identify led health information by removing all references to individually identifiable information.

We may contact you to provide appointment renders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written requires to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

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

(Please Print Name)______________________________ (Signature)______________________________(Date) ____________