

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date _____

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Initial

Sex M F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE

| | |
|--|--|
| <p>Father's/Guardian's Name _____</p> <p>Address (if different from patient's) _____</p> <p>Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small></p> <p>Employer _____</p> <p>Soc. Sec. # _____ Birthdate _____</p> <p>Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name _____</p> <p>Phone No. _____</p> <p>Address _____</p> <p>Group # _____ Policy # _____</p> | <p>Mother's/Guardian's Name _____</p> <p>Address (if different from patient's) _____</p> <p>Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small></p> <p>Employer _____</p> <p>Soc. Sec. # _____ Birthdate _____</p> <p>Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name _____</p> <p>Phone No. _____</p> <p>Address _____</p> <p>Group # _____ Policy # _____</p> |
|--|--|

Is your child eligible for treatment under Medical Assistance? Yes No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

| | |
|---|---|
| YES NO | YES NO |
| Has child complained about dental problems? <input type="checkbox"/> <input type="checkbox"/> | Is fluoride taken in any form? <input type="checkbox"/> <input type="checkbox"/> |
| Does child brush teeth daily? <input type="checkbox"/> <input type="checkbox"/> | Any injuries to mouth, teeth, head? <input type="checkbox"/> <input type="checkbox"/> |
| Does child use floss every day? <input type="checkbox"/> <input type="checkbox"/> | Any unhappy dental experiences? <input type="checkbox"/> <input type="checkbox"/> |
| Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> <input type="checkbox"/> | |

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

MEDICAL HISTORY

| | |
|---|-------------------|
| YES NO | Medications _____ |
| Is Minor/Child under care of physician now? <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Receiving any medication or drugs? <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Ever been hospitalized? <input type="checkbox"/> <input type="checkbox"/> | Allergies _____ |
| Ever had surgery? <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Is there excessive bleeding when cut? <input type="checkbox"/> <input type="checkbox"/> | _____ |

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

| | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

The information that 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 in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian

Date

I certify that my minor/child is covered by insurance with:

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian

Date



AUTHORIZATION

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE

FINANCIAL POLICY AND AGREEMENT

In an effort to provide you with quality dental care, we have expanded our payment policy. We will use our expertise to help you obtain the maximum benefits from your insurance policy. We expect full payments when services are rendered unless prior arrangements are made.

PLEASE SELECT DESIRED PAYMENT METHODS.

- Payment by Cash or Check
- Automatic billing to your Visa, MasterCard, American Express, or Discover
- 3rd party dental financing plan - We will be happy to assist you with applying for financing should you so desire.

• **INSURANCE:** We will file your insurance claims. You are expected to pay in full if we can not verify your insurance coverage at the time of service. After 30 days, any unpaid balance will accrue 1.5% monthly interest.

• **CHARGES:** You will be responsible for all insurance deductible, patient co-payments, the remaining balance of charges not paid by insurance within 30 days, broken appointment fees and any outstanding balance on your account which includes any dependents for all services rendered by Drs. Lee, Grant and Salem, Grand Central Dental of Manhattan PC, Diamond Dental PC & their staff. There is a monthly interest of 1.5% for all unpaid balance after 30 days from the date of service.

• **Broken Appointments:** We reserve the right to charge \$30 per half hour for all failed appointments without 24 hours prior notice. For two hours or longer appointments, we need to be notified 48 hours prior.

Our office participates with Visa/MasterCard Health Care Incentive Program, which will enable you to use your Visa/MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis.

PLEASE SIGN TO ACKNOWLEDGE OUR OFFICE FINANCIAL POLICY.

I assign my insurance benefits to the providers listed above. I understand that this form is a valid financial agreement. I certify that I have read and understand the above information.

Signature of Patient or Guarantor Print Name Today's Date

Authorized Healthcare Form & Credit Card Financial Agreement Contract
Automatic Credit Card Charge Authorization

I, _____, authorize Grand Central Dental of Manhattan PC and Diamond Dental PC, to keep my signature on file and to charge my MasterCard or Visa or American Express or Discover or Bank Debit Card account as indicated below for any outstanding balances on my accounts.

I authorize payments of \$_____ to be charged on the __first, __second, __third, __fourth week, and _____ of every month until all the remaining balance on my account is paid.

Patient Name: Patient's Date of Birth Today's Date

Credit Card Number Visa / MasterCard / AX / Discover
Credit Card Type Expiration Date

Signature of Card Holder Print Card Holder / Guarantor's Name

Credit Card Holder Billing Address: Credit Card Imprint

Diamond Dental, P.C.
Grand Central Dental of Manhattan, P.C.

Drs. Lee, Grant & Salem

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 (05/01/06), 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 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 a 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, 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1 for each page, \$25 per hour for staff time to locate and copy your 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. 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 Web site 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:

Diamond Dental, P.C.

Karina Pereyra, 914-472-9001

Grand Central Dental of Manhattan, P.C.

Maria Calderon, 212-682-1488

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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.

{Please Print Name}

{Signature}

{Date}

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)

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.
This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).