rye pediatric dentistry

130 Theodore Fremd #M2, Rye, NY 10580
Tel: 914.967.0000 ■ Fax: 914.967.0149 ■ Email: care@ryekids.com
www.ryekids.com

We are excited to welcome you and your family to our practice. We look forward to working with you to maintain your child's oral and dental health. **Please fill out this form as completely as possible.** If you have any questions, we will be happy to help.

NOTE: Please add our office **phone and email address** as a contact in your cell phone address book. Should an emergency arise, you may send a cell phone picture to our secured office email address. The photos will then be forwarded to the doctors for immediate evaluation.

Today's Date: _____/_____/_____

1. Tell Us About Your Child

Child's Name _____
Last First MI
Nickname _____ ☐ Male ☐ Female

Child's Birthdate____/____/____ Child's Age _____

Child's Home # (_____)_____

Child's Home Address_____

_____

Favorite TV Program, Activity, Instrument, Video Game

_____

Does your child play sports? ☐ Yes ☐ No
If yes, what sports _____

How did you hear about office? (Please list name)
☐ Pediatrician/Other Dentist_____
☐ Friend _____
☐ Google ☐ Yelp ☐ Dr. Oogle ☐ Insurance company
☐ Local newspaper ☐ School/Church/Synagogue
☐ Westchester Magazine (Top Doctor Issue)
☐ Other_____

2. Mother's Information

Name _____

Birthdate ____/____/____

Employer_____

Work Phone (_____)_____

Home Phone (_____)_____

Cell Phone (_____)_____

SSN _____

E-mail Address _____

3. Father's Information

Name _____

Birthdate ____/____/____

Employer_____

Work Phone (_____)_____

Home Phone (_____)_____

Cell Phone (_____)_____

SSN _____

E-mail Address _____

4. Who is accompanying the child today?

Name _____

Relationship _____

5. Person Responsible for Account

Name _____

Billing Address _____

City_____ State _____ Zip_____
Home Phone (_____)_____

5a. Insurance/Financial Information

Name of Dental Insurance Company _____

Telephone # of Dental Insurance _____

Policyholder ID #_____

Group # _____

Annual Deductible Amount _____

Annual Maximum _____

*Most fields may be answered by calling your dental insurance directly.
*First time patients, **please bring** your dental insurance card to office.

Additional Health Flex Plan (through employment)?

☐ Yes ☐ No

6. Dental History

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If not, who was the previous dental care provider for your child? Doctor_____

Phone (_____)_____

When was your child's last exam? _____/_____/_____

When were x-rays last taken? _____/_____/_____

Prior dental traumatic injury? _____/_____/_____

Does the child require a pre-medication before dental treatment? ☐ Yes ☐ No

Has your child had any orthodontic treatment, and if so, who performed the treatment? ☐ Yes ☐ No

_____

_____

Has your child had a history of the following, and if so, when did they stop:

☐ Bedtime bottle ☐ Fluoride Vitamins ☐ Pacifier
☐ Breast feeding ☐ Iron Supplements ☐ Teeth grinding
☐ Bottled water ☐ Mouth breathing ☐ Snoring
☐ Thumbsucking ☐ Filtered water ☐ Finger sucking
☐ Fingernail biting ☐ Sleep Apnea
☐ Non-fluoridated water
☐ Other habit: _____

What kind of multivitamins does your family use, if any?:

☐ Chewable ☐ Gummy ☐ Liquid Drops ☐ None

Does your child use:

☐ Floss ☐ Flossers ☐ Fluoride Mouthrinse (i.e. ACT)
☐ None*

How frequently does your child floss:

☐ Daily ☐ Frequently ☐ Infrequently* ☐ Never*

*****Do not worry! We will teach your child the importance of flossing!

Please list any questions, concerns, or comments you may have :

_____

_____

7. Health History

Child's Physician_____

Phone (_____)_____

Date of last physical exam _____/_____/_____

Under the care of a physician? ☐ Yes ☐ No

Ever been hospitalized overnight? ☐ Yes ☐ No

7. Health History (cont.)

Ever had surgery? ☐ Yes ☐ No

What kind of surgery: _____

Does your child have any allergies? ☐ Yes ☐ No

If yes, please list:

_____

_____

Any adverse reactions to medications?

☐ Yes ☐ No

If yes, please list which medication:

_____

_____

Has the child ever had any of the following conditions?

☐ Artificial Bones/Joints
☐ Asthma
☐ Anemia
☐ ADHD/Autism
☐ Cancer/Tumors
☐ Cleft lip/Palate
☐ Congenital Heart Defect
☐ Developmental Delay
☐ Ear/Hearing
☐ Epilepsy
☐ Fainting/Seizures
☐ Glucose 6 Phos. Dehy. Def.
☐ Heart Murmur
☐ High/Low Blood Pressure
☐ Kidney
☐ Jaw Problems TMJ/TMD
☐ Leukemia
☐ Liver/Hepatitis
☐ Artificial Heart Valve
☐ Abnormal Bleeding
☐ Arrhythmia
☐ Blood Transfusion
☐ Birth Defects
☐ Crohn's Disease
☐ Cerebral Palsy
☐ Diabetes
☐ Endocrine Function
☐ Eyes/Vision
☐ Glaucoma
☐ Headaches
☐ Hemophilia
☐ HIV/AIDS
☐ Liver/Hepatitis
☐ Jaundice
☐ Lungs
☐ Lymphoma
☐ Malignant Hyperthermia (family history)
☐ Methemoglobinemia
☐ Metabolic Disorder
☐ Milk Sensitivity: Casein
☐ Milk Sensitivity: Lactose
☐ Psychiatric Issues
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Speech
☐ Sickle Cell
☐ Tuberculosis
☐ Thyroid
☐ Tonsillitis
☐ Surgeries/Operations
☐ Ulcerative Colitis
☐ Other _____

_____

Please list any unlisted significant medical issues:

_____

_____

_____

Please list **all** medications **and** dosages your child currently takes: _____

_____

_____

8. I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence.

9. It is also my responsibility to inform this office of any changes in my child's medical status.

10. I am the parent, guardian, or personal representative of the child listed above. There are no court orders in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

11. I understand that the dentists at Rye Pediatric Dentistry will make courtesy initial evaluations of emergencies via cellular phone photos, should I (the parent/guardian) make this request. I agree that communication may be made via secured email exchanges between myself (parent/guardian) and the doctor, the office will maintain strictest measures to protect family privacy.

12. In the event that I am unable to bring my child in for an appointment, the following individuals have my permission to accompany my child and make any necessary decisions for my child's care. This includes consenting to any necessary treatment plan changes.

IMPORTANT: The legal guardian must accompany their child/children for the first appointment.

Individuals authorized to bring my child to subsequent visits:

NAME: CONTACT NUMBER:

_____ _____

_____ _____

_____ _____

Parent/Guardian's Signature_____ Date_____

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CONSENT FOR TREATMENT

TREATMENT

I am aware that dental treatment will be rendered by Drs. Paul Chu, Mark Liu, or Stacey Lubetsky- licensed practitioners in the specialty of pediatric dentistry, as well as trained dental auxiliaries. I consent to treatment as indicated by sound and prudent dental practices that are diagnosed or discovered during the course of my child's dental care. The nature and purpose of the treatment to be rendered will be explained to me and no guarantee will be made that the results will be to my complete satisfaction although it is believed that such results will be satisfactory.

I agree to the use of topical and local anesthetic agents as indicated for my child's dental treatment, if warranted. I further consent to the taking of radiographs (x-rays), photographs, and impressions when they are indicated for the purpose of diagnosing and planning treatment. I understand the office employs the use of digital radiography, and adopts the philosophy "As Low As Reasonably Achievable (ALARA)" in its approach to dental x-rays in children. I expressly agree that the office may use such materials for educational and scientific purposes including seminar instruction, publication of literature, and demonstration of methods and techniques of pediatric dentistry. I understand that suitable measures will be taken to maintain my child's anonymity. I understand that all original dental records are the property of Rye Pediatric Dentistry and cannot be taken or sent from this office. Copies of dental records will be provided upon written or verbal request of a dentist, physician, parent, or legal guardian.

BEHAVIOR MANAGEMENT TECHNIQUES

I authorize the doctors of Rye Pediatric Dentistry to use its judgment to decide when particular behavior management techniques would be appropriate to obtain cooperation from my child. I understand that cooperation is necessary when performing dental procedures to allow for the safest possible setting and the best possible treatment outcome. I give my written and implied consent to use the following procedures when necessary:

Tell-show-Do
Tell-show-do is a technique used with children to explain what is expected at each visit. We *tell* them what will be done, *show* them how it will be done, and then *do* what we have explained to them. Praise is used to reinforce the child's cooperative behavior.

Voice control
Voice control is a method used for a child who is capable of understanding, but is not listening to requests. The attention of a child is gained by changing the tone or increasing the volume of the dentist's voice **without** getting angry with the child. Praise is used to support the child's attention to the dentist.

Restraint
Active: Active restraint by parent or dental personnel protects the child from injury during a dental procedure. The parent, dentist, or assistant helps hold a child's head, arms, or legs to prevent harmful movements during treatment.
Passive: Passive restraint with a pedi-wrap is sometimes used to prevent injury to an uncooperative child and to enable the dentist to provide the necessary treatment. The pedi-wrap is mainly used for very young children that require emergency treatment.

Nitrous oxide
Nitrous oxide (laughing gas) is administered to the anxious child through a small breathing mask, which is placed over the child's nose. This allows the child to relax during the procedure, but does not "put the child to sleep". After the mask is removed, the effects of the gas wear off in approximately 5 minutes through breathing with 100% oxygen (what is seen in football games.)

Sedation/operating room
If we are unable to gain your child's cooperation with the following procedures, the doctors of Rye Pediatric Dentistry may recommend treatment under sedatives or general anesthesia. This is a separate appointment and will be discussed further if and when it is recommended for your child.

I hereby state that I have read and understand all of the above information and give my written and implied consent for my child to be treated by Rye Pediatric Dentistry.

_____ _____
Parent/Guardian Signature Date

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OFFICE POLICIES

1) Appointment Policy

Your appointment is reserved specifically for your child. Changes may affect other patients. If a change or cancellation is unavoidable and conflicts arise, please call us at the office at least **24 business hours** in advance so that we may offer that time to another patient who is in need of care. Our office staff will always contact your family via phone and email to remind you of your child's appointment.

We value your time and we will make every effort to stay on schedule. To do so, it is ideal to arrive 5 minutes before your child's reserved appointment. We reserve the right to reschedule late patients or dismiss habitually late patients from the practice.

2) Payment Policy

We request payment in full for treatment rendered (at each visit) unless prior financial arrangements have been made. We will discuss with you the fees prior to treatment, and make arrangements if necessary. The office accepts Cash, Check (Verified by TeleCheck), Visa, MasterCard, Discover, American Express, or CareCredit.

Payment Plans

If it is necessary for your child/children to have extensive dental treatment, we offer CareCredit. CareCredit is a convenient, low minimum monthly payment program specifically designed to pay for health care services. Should you not be approved for CareCredit, a short-term monthly payment plan can be arranged with the office manager. A credit card must be placed on file in order to pay in monthly installments.

3) Insurance Policy

Rye Pediatric Dentistry is a preferred provider for several insurance companies. It is the policyholder's responsibility to: ensure coverage is intact; understand certain insurance companies require an annual deductible be met; understand their maximum annual deductible; and, understand that not all procedures will be paid 100% by the insurance company.

If the office does not participate with your family's respective dental insurance plan, the office will still be happy to see your child and work with your family's dental insurance plan! Please speak to our office for details.

It is our hope that every child grows up with a happy and healthy smile!!

Signature:_____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my or my child's treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used, or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices*, but was unable to do so as documented below.

Date:	Initials:	Reason:

PATIENT COPY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable 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 is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA 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 includes, but is not limited to, activities such 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 are 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-identified health information by removing all reference to an individual or any individuals.

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

All other uses and disclosures will be made only with your written authorization. You may revoke the authorization in writing and we are required to honor and abide by that written request, except in relation to disclosures made prior to that date.

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

- The right to request restrictions on certain uses, and disclosures, of protected health information, including information disclosed to family members, other relatives, close personal friends, or any other person you identify. 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.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

PATIENT COPY

This notice is effective as of January 01, 2009 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

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Office of Civil Rights
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202-619-0257
Toll free: 1-877-696-6775