First Smiles
PEDIATRIC DENTISTRY

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone Number:_____ E-mail: _____

Cell Phone Number: _____

Work Phone Number: _____

PARENT/GUARDIAN INFORMATION- Please complete if different from above

Name: _____

Social Security #:_____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Employer: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability ACT (HIPAA), 1996
http://www.hhs.gov/ocr/hipaa/finalreg.html

PARENT/GUARDIAN GIVING CONSENT

Last Name:_____ First Name: _____
Address:_____
Telephone:_____ E-mail: _____

TO THE PARENT/GUARDIAN
PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.

Notice of Privacy Practices:
You have the right to read out Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

4 Executive Park Drive, Albany, NY 12203

Right to Revoke:
You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or your children or to continue treating you/them if you revoke this Consent.
I,_____(print name) have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature:_____ Date:_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representative's Name: _____
Relationship to Patient: _____
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

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First Smiles and Your Dental Insurance
How We Work Together

The staff at First Smiles Pediatric Dentistry is pleased that you have insurance benefits to help with the cost of your den tal care. We would like to help you obtain maximum use of your benefits. With this in mind, please read the information on our insurance claims process so we can work together ensuring this benefit.

Do You Accept My Insurance? How Much Will They Pay?

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means we work with literally thousands of companies. Although we maintain computerized histories of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have; as a result it is ONLY AN ESTIMATE. If you would like to know your exact out-of-pocket portion we will be happy to submit a pre-determination to your insurance company prior to treatment. This does delay your treatment approximately 3-4 weeks but will give you the financial information you may require.

I Thought I Paid My Portion, But I Still Got A Bill. Why?

We base the out-of-pocket portion of you bill on the most current data, but there are many factors that can affect our estimate. There may be a deductible or you may have received treatment in another office prior to joining our dental family that is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefits. Insurance companies do not notify us of changes to your benefits, they only notify you. In addition, insurance companies will typically pay benefit on what they feel is reasonable and customary. These rates can be significantly lower than those of a specialty practice. If these situations apply to you, please let us know when we estimate your treatment plan.

Insurance Didn't Pay, Now What?

We bill your insurance as a courtesy. If your insurance does not pay within 90 days, we reserve the right to bill you in full for the services provided and let you collect the insurance funds. This is rare, but it is important that you recognize the insurance you have is a legal contract between you and your insurance company. Our office is not and cannot be a part of that contract. Ultimately, you are responsible for all charges incurred in our office.

Financial Options

To keep billing costs at a minimum, we request payment in full for your out-of-pocket portion at the time of service. We accept VISA, MasterCard, Discover and American Express. If you are in need of extended finance options we offer *CareCredit*. Just ask a member of our staff for an application.

We welcome you to our dental family and look forward to helping your child/children get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of dental treatment.

Signature _____ Date _____

Patient's Name _____

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CONSENT FOR TREATMENT

_____Initial Necessary radiographs (x-rays) and photographs for the diagnosis and treatment of my child's dental condition will be recommended. Comprehensive dental treatment and procedures include an examination, teeth cleaning, fluoride application, fillings, crowns, endodontic treatment (tooth nerve treatment), extractions, and/or space maintainers under nitrous oxide gas.

_____Initial Local anesthetic (numbing solution) and nitrous oxide may be administered by the dentist when necessary to prevent discomfort and anxiety during dental treatment.

_____Initial Dental treatment has potential risks and consequences. Likewise, so does the refusal or denial of dental treatment. Untreated decay may lead to pain, swelling, infection and tooth loss. Risks involved with treatment include allergic reactions to medications, filling materials, and latex. Prolonged anesthesia (numbness) may occur therefore, it is best for you to monitor your child after the dental procedure to prevent biting of lips, cheeks and tongue.

_____Initial Patients undergoing dental procedures are subject to the risk of medical complications including, but not limited to nausea and vomiting, prolonged numbness, secondary infection, post – operative swelling and allergic reactions.

_____Initial If a cancellation is necessary, please notify the office staff 48-hours prior to the appointment. Failure to notify the office in a timely manner may incur no show fees

_____Initial I authorize and direct payment of the dental benefits otherwise payable to me, directly to the dental office

_____Initial I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan

_____Initial . I consent to the use and disclosure of my protected health information to carry out insurance claims

_____Initial My child/ren must always be accompanied by a parent/guardian, or an adult with a letter from parent/guardian authorizing them to make any decision regarding dental care on that visit or subsequent visit.

_____Initial Non-Sufficient Funds**:** A charge of $35.00 will be assessed on each check returned by the bank because of "Non-Sufficient Funds" (NSF).

I understand and have had ample opportunity to discuss all of the above information. My questions have been fully answered.

Name of Child_____ Date of Birth_____

Parent/Guardian Signature_____Print_____Date_____

Relation to Patient _____

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Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Child's Dental History

Child's Full Name:_____ Birthdate:_____ Age:____ ☐Male ☐Female
Reason for today's visit:_____ Former Dentist: _____
Date of last dental visit:_____ Date of last dental x-rays:_____

Please check all that apply to your child:
Tooth Pain___ Bleeding Gums___ Finger/ Thumb Sucking___ Clicking or Popping Jaw___
Cavities___ Sores or growths in the mouth___ Pacifier User___ Broken Teeth or Fillings___
Grinding teeth___ Breast Feeding___ Bottle Feeding___ Loose Teeth ___

Child's Health History

Pediatrician:_____ Office Phone:_____

Please check all that apply to your child:
Current Medications/Vitamins/Herbs:_____

☐Tobacco/Chemical Substances	☐Kidney Disease	☐Psychiatric Care
☐Seasonal Allergies	☐Artificial Joints ☐Anemia	☐ADHD/ADD
☐Asthma ☐Cancer	☐Diabetes ☐HIV/ AIDS	☐Congenital Birth Defects
☐Hepatitis- Type_____	☐Tuberculosis	☐Developmental Delay
☐Sensory Disorder	☐Thyroid Disease	☐Epilepsy/Seizures
☐Heart Condition/Murmur	☐Autism	☐Blood Disorders
☐Pregnant	☐Birth Control	☐Liver Disease
☐Allergy to Medications/Foods: List :_____		☐Chemotherapy
☐Operations: List :_____		
☐Other:_____		

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 me or my child's health. I authorize the dentist to release the following information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or the dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I will be responsible for the remaining balance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____ _____
Parent/Guardian Signature **Relationship to Patient** **Date**