NEW ROCHELLE KIDS DENTAL, PC

77 Quaker Ridge Road #210, New Rochelle, NY 10804
Tel: 914 632 2800 / FAX: 914 560 2075 / www.newrochellekidsdental.com

Date:_____

Child's Name:_____ Nickname: _____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Sex: M / F Age:_____ Birth date:____/_____/_____ SS#:_____
(Circle One)

Name of Responsible Party:_____ Relationship to Child:_____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Sex: M / F Age:_____ Birth date:____/____/_____ Single Married Widow Separated Divorced SS#: _____
(Circle One) (Circle One)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____Occupation:_____

Employer: _____

Employer Address: _____ City: _____ State:_____ Zip: _____

Family Member Information

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Policy Holders Name:_____ Relationship to Patient:_____ SS#:_____ DOB____/____/ ____

Name of Employer: _____ Employer Address:_____ State: _____

Insurance Co._____ Group #:_____ Address: _____

Secondary Insurance Information

Policy Holders Name:_____ Relationship to Patient:_____ SS#:_____ DOB____/____/ ____

Name of Employer: _____ Employer Address:_____ State: _____

Insurance Co._____ Group #:_____ Address: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to New Rochelle Kids Dental to check and verify my credit and/or employment history. I further understand that New Rochelle Kids Dental will assist me in filing my child's claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my child's photos for educational purposes.

I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 24 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 3% per month. Thank you for your cooperation.

Parent or Guardian: _____

(please complete both side)

Medical History

Please indicate with a YES or NO. Does your child currently have/previously had any of the following health problems?

_____ Allergies (Food, Dust, Drug, Unknown)
If yes, Please list_____
_____ Rheumatic Fever / Rheumatic Heart Disease
_____ Congenital Heart Disease or Hearth Murmur
If yes, Premed Needed? _____
Name of Pharmacy: _____
Pharmacy Phone Number: _____
_____ Glandular or Hormonal Problems
_____ Diabetes/Blood Sugar Problems
_____ Arthritis or Rheumatism (painful, swollen joints)
_____ Convulsions, Seizures, Fainting or Epilepsy
_____ Anemia or Blood Disorders
_____ High/Low Blood Pressure
_____ Asthma or Hay Fever (Please Indicate) If yes, please list any current medications: _____

_____ Any Current/Recent Injuries
_____ Childhood Illness
_____ Blood Transfusion
_____ Any Prolonged Bleeding/Bruises Easily
_____ Kidney or Bladder Problems
_____ Tuberculosis or Pneumonia
_____ Liver Problems, Jaundice or Hepatitis
_____ Accidents or Severe Infections
_____ Psychological or Emotional Problems
_____ Any Pending/Recent Surgery
_____ Speech, Learning, or Hearing Disorders
_____ ADD/ADHD
_____ Autism

Are your child's Immunizations Current? _____
Please explain any other medical concerns/Current Medication(s): _____

Dental History

Date of Last Dental Visit _____ By Dr. _____
Do you have any Current Records (including x-rays) from another practice? ☐Yes ☐No
Has your child complained about any dental problems? _____
Any injuries or surgeries to mouth, teeth, head? ☐Yes ☐No If yes, please describe: _____
_____
Does your child still take the bottle or sippy cup? _____
Does your child brush daily? ☐Yes ☐No How Often? _____
Is Dental Floss used? ☐Yes ☐No

Please check each box if your child has any of the following mouth habits
☐Thumb Sucking ☐Mouth Breathing ☐Pacifier ☐Nail Biting ☐Finger Sucking ☐Grinding ☐Other_____

How does your child receive Fluoride?
☐Water Supply ☐Dentist ☐Toothpaste ☐Vitamins ☐Tablets ☐None
☐Other: _____
Child's Attitude Towards Dentistry: _____
Reason for Today's Visit/Chief Concerns: _____

Authorizations

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)

And assign directly to New Rochelle Kids Dental (Dr.Kim) 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 submission, whether manual or electronic.

_____
(Signature of Parent/Guardian) (Date)

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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 04/14/03, 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 reservce 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 prvacy practices, or for additional copies of this Notice, please contract 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 of 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, counteringtelligence, 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 / Treatment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services which may be of interest to you.

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 $1.00 per page for paper records or $100 for the entire record (whichever is less). If you prefer, we will prepare a summary or an explanation of your health information for a free. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accouting: You have the right to receive a list of instances in which we or our business assocates disclsoed 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 restictions, 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 restict 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: Moon Sun Kim D.D.S.

Telephone: (914)632-2800 Fax: (914)560-2075

Address: 77 Quaker Ridge Road Suite 210, New Rochelle, NY 10804

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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 obatined because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

Section B: TO THE PATIENT – 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 operations.

Notice of Privacy Practices: You have the right to read our 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 siclosures 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 encourage you to read it carefully and completely before signing 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 inssue 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 revisions of our Notice, at any time by contracting:

Contact Person: Michelle Kim, D.D.S.

Telephone: (914) 632-2800 Fax: (914) 560-2075

E-mail: _____

Address: 77 Quaker Ridge Road New Rochelle, NY 10804

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 thisConsent 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 to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, 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.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and siclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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Office Policy and Regulations

Please read this form carefully and sign below. By signing it, you agree to follow our office policy and regulations that have been developed to benefit both the practice and patients.

1. Patient responsibility that is assigned by your insurance policy is due at the time of treatment and/or service rendered.
2. Changes in insurance policy, whether it is changes in your group number or changes in insurance carrier, should be informed as soon as possible. If you let us know at the time of an appointment and we are not able to verify your coverage with the insurance, the service rendered will be your responsibility and we will assist you in receive reimbursement from your insurance.
3. Changes of your home address, phone number, and work number should be notified promptly.
4. Appointments missed, broken or cancelled within 24 hours will be subject to a cancellation charge of $25. Please plan ahead and make sure to inform us at least 24 hours before if you cannot keep an appointment to avoid unnecessary charges in your account.
5. If your check payment is returned for insufficient funds from your bank, you will be charged $25 additional. Unpaid balance aged more than 30 days will be subject to a 3% late charge additional to the balance.
6. An open account over 6 months with unpaid balance will be subject to collection action. Once the account is sent to our collection agency, we no longer accept your child(ren) as active patient(s). You may request release of dental records when a full payment is made to the collection agency.
7. Please come right on time for your appointment. If you come more than 15 minutes late, we cannot guarantee that your child can see the doctor for the scheduled service.
8. If your account goes into collection you will be responsible for any and all charges incurred including but not limited to: prior balance, interest charges, late charges and collection fees. Future appointments will be at our discretion.

Composite Fillings (Tooth-Colored Fillings)

Tooth- colored fillings are made from durable plastics called composite resins. Similar in color and texture to natural teeth, the fillings are less noticeable, and much more attractive, than silver fillings (amalgam). Because composite resins are tooth-colored, they look more natural than other filling materials. Your child can smile, talk and eat with confidence. In addition, tooth-colored fillings are compatible with dental sealants. A tooth can be filled and sealed at the same time to prevent further decay.

Tooth-colored fillings are not for every tooth. They work best in small restorations and low-stress areas. Tooth-colored fillings may cost a bit more than silver fillings because they take longer to place.

Take care of a tooth-colored filling the same way you take care of a silver filling: Brush, floss, and visit dentist. Any filling will last longer with good oral hygiene. Dentist will regularly check the fillings for color change, leakage, or unusual wear and inform you of the need for repair or replacement.

As of 01/01/2007, Amalgam (silver filling) is no longer used. Resin Composite (white filling) is the service provided for the minor restoratives.

I agree to your Office Policy and will follow the regulations.

Date Signature Relation to Patient