



PLEASE LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE. LIST MULTIPLE SOURCES IF APPLICABLE:

DOCTOR, PATIENT, WALK IN, GOOGLE FACEBOOK, OTHER, NAME OF REFERENCE _____

PATIENT INFORMATION

Name _____ Birth date: _____ Age _____ Sex: M ___ F ___ Other ___

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: (____) _____ E-Mail: _____

Person to contact in case of emergency:

Name: _____ Relationship to patient: _____ Phone Number:(____) _____

RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____ Birth date: _____

Social Security #: _____ E-Mail: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

INSURANCE INFORMATION

If you wish to have our office submit your dental claims for you, please fill this section out **completely**.

Primary Dental Insurance

Name of Policy Holder: _____ Relationship to Patient: _____ Birth Date: _____

Social Security Number/ID Number: _____ Employer: _____

Work Phone: (____) _____ Insurance Company: _____

Group Number: _____ Address: _____ City _____

State: _____ Zip: _____ Phone: (____) _____

Secondary Dental Insurance

Name of Policy Holder: _____ Relationship to Patient: _____ Birth Date: _____

Social Security Number/ID Number: _____ Employer: _____

Work Phone: (____) _____ Insurance Company: _____

Group Number: _____ Address: _____ City _____

State: _____ Zip: _____ Phone: (____) _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former/Current Dentist: _____ Date of last dental X-ray: _____

Address: _____ City _____ State: _____ Zip: _____ Phone: (____) _____

MEDICAL HISTORY

Physician's Name: _____ Phone Number: (____) _____

Address: _____ City _____ State: _____ Zip: _____

Date of Last Visit: _____ Has patient ever had any serious illnesses or operations? Yes ___ No ___

If yes, describe type and date: _____

Check if the patient has had any of the following: (If none, indicate here) NONE _____ (Initial)

<input type="checkbox"/> ADD/ ADHD	<input type="checkbox"/> DIABETES	<input type="checkbox"/> IMMUNOLOGIC CONCERNS	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> AIDS/ HIV	<input type="checkbox"/> EPILEPSY/ SEIZURES	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> MONONUCLEOSIS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> EYE DISORDERS	<input type="checkbox"/> PREGNANCY (teens)	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> SICKLE CELL DISEASE	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> PSYCHIATRIC CARE
<input type="checkbox"/> AUTISM	<input type="checkbox"/> HEARING PROBLEMS	<input type="checkbox"/> DEVELOPMENTAL DELAY	<input type="checkbox"/> PSYCHICALLY DISABLED
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART AILMENTS	<input type="checkbox"/> LIVER PROBLEMS	<input type="checkbox"/> SINUS PROBLEMS
<input type="checkbox"/> CEREBRAL PALSY	<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> MEASLES	<input type="checkbox"/> THYROID DISORDER
<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> TONSILLITIS	<input type="checkbox"/> DIGESTIVE CONCERNS	<input type="checkbox"/> OTHER: _____

Medications: (prescription, over-the-counter, vitamin supplements) _____

Allergies: _____

Does your child take vitamins with Fluoride? **Yes** ___ **No** ___

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 my/the patient's health.

Signature x _____ Relationship _____ Date _____

Consent for Treatment

This is verification that I have brought my child for dental examination and treatment. I hereby consent to have all doctors and associates of Clifton Pediatric Dental Care perform dental examinations, cleanings, fluoride treatments, dental restorations (including, but not limited to, tooth colored fillings, and stainless steel crowns, dental x-rays (when necessary), dental extractions and any other procedures deemed necessary or advisable as a corollary to the planned procedures. I further agree to the use of local anesthetic agents.

I understand that there are techniques in pediatric dentistry, which are signed to manage behavior. These techniques may include: excluding a parent from the room on occasion, raising and lowering the doctors voice to aid in communication, mild restraint by a parent, assistant, or doctor and/or similar techniques. I understand that these techniques will be utilized as means of ensuring a safe, productive, dental experience for my child.

I have been informed and understand that most dental procedures can be accomplished without complication. There are, however, possible risks inherent in dental procedures, these risks include: post-operative pain, infection, swelling, bleeding and/or injury to adjacent soft issue.

I also understand that it may be necessary, in the best judgment of the doctor to alter any planned treatment. I understand that all payment is due at the time of the procedure.

I hereby give my free and voluntary consent for the treatment to be rendered

X _____
Signature of Patient, Parent or Guardian Date



Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our patient information sheets before seeing the doctor.

All payments and co-payments are due at the time of the appointment. Payment must be made by cash, check, Mastercard, Visa, or Discover.

Dental Benefits:

We are pleased that many of you have dental benefits and our office will assist you in obtaining the maximum benefits specified in your contract. However, your benefits are a contract between you and your insurance carrier.

We will assist you in determining your benefits as best as we can because plans differ from carrier to carrier and policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan.

At Clifton Pediatric Dental Care, we strive to provide the best individually tailored care for our patients regardless of insurance coverage. **For instance, we strongly believe, based on research that our patients will benefit from fluoride treatments at least every 6 months. Your insurance plan may only cover it once a year or not at all.** We know how confusing insurance plans can be. If you have any questions, feel free to ask us. We may be able to help you.

1. Co-payments quoted at the time of service are an estimate and the actual payment due may differ after your insurance carrier has paid their share of your bill. Any balance remaining after your insurance company's payment will be your responsibility.
2. Balances with benefit claims outstanding more than 60 days may be reverted back to the patient.
3. Not all services are a covered benefit in all contracts. Some carriers and employers select only some services to be covered. You are responsible for payment of all services regardless of the payable benefit.

Additional Fees

Returned Check Fee:

Our bank charges us a fee for any check that is returned for "insufficient funds" and a \$35.00 fee will be added to the patient's bill if this occurs.

Appointment Policy:

We respect your time and ask that you respect ours by honoring your appointment commitment. A broken appointment is a loss to everyone. Remember, once you have made an appointment, this time is reserved for you. **Please give us at least 24 hours notice if you are unable to keep your appointment.** This will allow us to accommodate the needs of other patients more readily. **If we do not receive a cancellation notice within 24 hours, a cancellation fee of \$50 per patient (\$100 per family) will be applied to your account.**

I have read the above Clifton Pediatric Dental Care Financial Policy. By my signature, I acknowledge that I understand and agree to abide by its terms.

Signature of Responsible Party: _____ Print Name: _____ Date: _____

Circle Relationship: SELF PARENT LEGAL GUARDIAN

Signature on File for Dental Insurance

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.
- I authorize release of any information relating to my dental claims.

X _____
Signed (Patient OR Insured Parent/Guardian) Date

- I assign dental benefit payments to be paid directly to Clifton Pediatric Dental Care from my insurance company.

X _____
Signed (Patient OR Insured Parent/Guardian) Date



6 Brighton Rd. Suite 105
Clifton, NJ 07012

Notice of Privacy Practices Patient Acknowledgement

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices

Patient(s) Name

Date of Birth

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

X _____
Signature of Patient, Parent or Guardian Print first and last name Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment 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) _____



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 protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 6/7/19, and will remain in effect until we replace it.

We reserve the right to change our privacy practice 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 received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and provide the new notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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 health information for any reason except those described in the notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professions, evaluating practitioner or provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: 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 your personal representative, 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 absence or incapacity in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for judicial and administrative proceedings. For certain law enforcement purposes; to avert a serious threat or health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of the protected health information of an 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).

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 sending us a letter to the address at the end of this notice. We will charge you a \$0.____ for each page, \$0____ per hour for staff time to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by electronic mail (e-mail.)