JOSEPH P. SCIARRA, D.D.S. & ASSOCIATES

PEDIATRIC & FAMILY DENTISTRY

PATIENT INFORMATION

PATIENT'S NAME	**DATE OF BIRTH** / /	**ADDRESS**	CITY, STATE, ZIP
PATIENT'S PHYSICIAN'S NAME	BUSINESS PHONE		ADDRESS
MOTHER'S NAME	DATE OF BIRTH / /	PHONE	EMAIL ADDRESS
SOCIAL SECURITY NUMBER	DRIVERS LICENSE		MOTHERS CELL PHONE
MOTHER'S EMPLOYER	BUSINESS PHONE		ADDRESS
MOTHER'S DENTAL INSURANCE	GROUP #		ADDRESS
FATHER'S NAME	DATE OF BIRTH / /	PHONE	EMAIL ADDRESS
SOCIAL SECURITY NUMBER	DRIVERS LICENSE		FATHER'S CELL PHONE
FATHER'S EMPLOYER	BUSINESS PHONE		ADDRESS
FATHER'S DENTAL INSURANCE	GROUP #		ADDRESS

DENTAL HISTORY

IS THIS THE PATIENT'S FIRST DENTAL VISIT EVER? **YES** ❍ **NO** ❍	IF NOT, WHO WAS THE PREVIOUS DENTIST?		CITY, STATE
HAS THE CHILD HAD ANY INJURY TO THEIR TEETH OR JAW? FALLS, BUMPS, CHIPS, ETC. **YES** ❍ **NO** ❍	PLEASE EXPLAIN:		
HOW DO YOU THINK THE CHILD WILL ACT TOWARD THE DOCTOR?			
WHO IS MOM AND/OR DAD'S DENTIST?			CITY, STATE
HOW OFTEN DOES YOUR CHILD BRUSH THEIR TEETH?	IS DENTAL FLOSS USED? YES ❍ NO ❍	IS TOOTHBRUSHING SUPERVISED? YES ❍ NO ❍	
DOES YOUR CHILD RECEIVE ANY OF THE FOLLOWING: FLUORIDE IN VITAMINS ❍ FLUORIDE TABLETS OR DROPS ❍ FLUORINATED WATER ❍ NONE ❍			

PATIENT HISTORY

	HAD IMMUNIZATIONS	*HAD DISEASE*		*HAD IMMUNIZATIONS*	*HAD DISEASE*
MUMPS	❍	❍	**RUBELLA**	❍	❍
MEASLES	❍	❍	**CHICKENPOX**	❍	❍
DPT	❍	❍	**HEPATITIS**	❍	❍
SMALLPOX	❍	❍	**POLIO**	❍	❍

ALL IMMUNIZATIONS UP TO DATE: ❍

OTHER:

NAME OF RELATIVE LIVING CLOSEST TO YOU	ADDRESS	PHONE
WHO REFERRED YOU TO OUR OFFICE? WE WOULD LOVE TO THANK THEM!		

PLEASE CONTINUE ON REVERSE SIDE

MEDICAL HISTORY	REVISED / /	REVISED / /	REVISED / /	REVISED / /	REVISED / /
PATIENTS GENERAL HEALTH ❍ GOOD ❍ FAIR ❍ POOR			PATIENTS APPETITE ❍ GOOD ❍ FAIR ❍ POOR		
PATIENTS LAST VISIT TO PHYSICIAN / /		BLOOD PRESSURE /		PULSE	

DOES THE PATIENT HAVE ANY HISTORY OF THE FOLLOWING:

YES	NO	CONDITION
❍	❍	RHEUMATIC FEVER
❍	❍	MENINGITIS
❍	❍	PNEUMONIA
❍	❍	BLADDER INFECTIONS
❍	❍	DIABETES MELLITUS
❍	❍	KIDNEY INFECTIONS
❍	❍	DOWN'S SYNDROME
❍	❍	ASTHMA
❍	❍	HIGH / LOW BLOOD PRESSURE
❍	❍	HEPATITIS
❍	❍	MULTIPLE SCLEROSIS

YES	NO	CONDITION
❍	❍	SINUSITIS
❍	❍	STREP THROAT
❍	❍	HAY FEVER
❍	❍	AUTISM
❍	❍	POSITIVE HIV TEST (AIDS)
❍	❍	MONONUCLEOSIS
❍	❍	CYSTIC FIBROSIS
❍	❍	TB
❍	❍	COLITIS
❍	❍	HEART MURMUR / DEFECT
❍	❍	SEIZURE DISORDERS (CEREBRAL PALSY)

YES	NO	CONDITION
❍	❍	FREQUENT NAUSEA OR VOMITING
❍	❍	HAS HAD BLOOD TRANSFUSIONS
❍	❍	HEMOPHILIA / BLOOD CLOTTING
❍	❍	WEARS EYEGLASSES
❍	❍	ANEMIA - TYPE:
❍	❍	SKIN PROBLEMS - TYPE:
❍	❍	ULCERS - TYPE:
❍	❍	EAR PROBLEMS - TYPE:
❍	❍	NERVOUS CONDITION - TYPE:

OTHER CONDITIONS WE SHOULD BE AWARE OF:

DOES THE PATIENT HAVE ANY OF THE FOLLOWING ALLERGIES?

YES	NO	ALLERGY
❍	❍	PENICILLIN
❍	❍	ERYTHROMYCIN
❍	❍	ASPIRIN
❍	❍	CODEINE
❍	❍	IBUPROFEN (ADVIL / MOTRIN)

YES	NO	ALLERGY
❍	❍	LATEX
❍	❍	LOCAL ANESTHETICS - NAME:
❍	❍	OTHER DRUGS - NAME:
❍	❍	ANY FOOD ITEMS - NAME:
❍	❍	ANYTHING ELSE WE SHOULD BE AWARE OF?

IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS? ❍ YES ❍ NO - IF YES, PLEASE EXPLAIN:

IS THERE ANY FAMILY HISTORY OF THE ABOVE CONDITIONS? ❍ YES ❍ NO - IF YES, PLEASE EXPLAIN:

HAS THE PATIENT EVER BEEN HOSPITALIZED? ❍ YES ❍ NO - IF YES, PLEASE EXPLAIN:

IS THE PATIENT BEING TREATED BY A PHYSICIAN? ❍ YES ❍ NO - IF YES, PLEASE EXPLAIN:

I HAVE REVIEWED THIS MEDICAL HISTORY WITH PATIENT / PARENT: / /

DOCTOR'S SIGNATURE DATE

To the best of my knowledge, the above information is correct and I will contact the office of any information changes. I do hereby grant Dr. Joseph P. Sciarra and/or his associates permission to request any medical, dental, or hospital records necessary for the general treatment of the above named patient. I do hereby authorize them to perform any and all treatment and consent to such methods, drugs, and agents as may be indicated in connection with the indicated dental care; such as dental fillings, crowns, x-rays, etc. I accept responsibility for any changes incurred during treatment rendered and understand that administrative costs will be added on past-due accounts. I also understand that there is a 24 hour cancellation policy. This consent shall remain in effect until canceled.

PLEASE NOTE: Payment is expected for services rendered at the time of the first visit. Financial arrangements for subsequent treatment may be made following diagnosis.

RECORDED BY: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

PAYMENT POLICY

Dear Parents / Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PLEASE NOTE: Payment Arrangements are requested at the time of your visit.

We now offer the following payments options:

- ○ Payment by cash
- ○ Payment by check
- ○ Payment by Credit Card: ○ AMEX ○ Mastercard ○ Visa ○ Discover
- ○ CareCredit Health Care Line of Credit *(for which you can apply for through our office any time)*
- ○ Automatic monthly billing to your Credit Card
- ○ Automatic billing of any am Amount not covered by your insurance to your Credit Card

Please make your choice and return this form to the front office staff before treatment. If you feel none of the above applies to you, please see the front office staff.

Thank you.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

FINANCIAL POLICY

Dear Parents:

Thank you for choosing our office for your children's dental needs. The following is our financial policy. We feel the best way to avoid misunderstandings is to provide a clear financial policy. Our main concern is that your children receive the proper and optimal necessary treatment. Therefore, if you have any questions or concerns about our policies, please do not hesitate to ask.

We ask that all our parents read and sign our Financial Policy.

Payments for services are due at the time services are rendered. We accept cash, checks, major credit cards and ATM cards for your convenience. We will be happy to help you process your insurance claim for reimbursement as long as it can be billed electronically.

If you have insurance, we may accept assignment of benefits. However, you must understand that:

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
- All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We do not determine the amount of cover-age and cannot be responsible for the decision of your insurance company or the limitations of your policy.
- A percentage of fees for services rendered, along with unpaid deductibles are due at the time of treatment.
- If the insurance company does not pay its portion within 30 days, we ask that you contact the carrier to help speed things up.
- If the insurance company does not pay its portion within 45 days, we require you to pay the balance due with cash, check or credit card.
- Remaining balances after the insurance payment are due in full within 30 days unless a payment plan has been signed.
- Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 2% per month.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again thank you for choosing our office for your children's dental needs. We appreciate your trust in us and we appreciate the opportunity to serve you.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

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 (MM/DD/YR), 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.

NOTICE OF PRIVACY PRACTICES

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 ir:,formation 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 $0._ for each page, $_ 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.

JOSEPH P. SCIARRA, D.D.S. & ASSOCIATES

PEDIATRIC & FAMILY DENTISTRY

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

PATIENT NAME: _____ PATIENT SIGNATURE: _____

DATE: _____

-OR-

PATIENT NAME: _____ PATIENT REP SIGNATURE: _____

AUTHORITY OF PERSONAL REPRESENTATIVE TO SIGN FOR PATIENT: DATE: _____

○ PARENT ○ GUARDIAN ○ POWER OF ATTORNEY ○ OTHER:_____

Please Note: It is your right to refuse to sign this Acknowledgment.

DENTAL OFFICE USE ONLY

I tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

○ An emergency prevented us from obtaining acknowledgment.

○ A communication barrier prevented us from obtaining acknowledgment.

○ The individual was unwilling to sign.

○ Other: _____

STAFF NAME: _____ STAFF SIGNATURE: _____

DATE: _____