Ivis M. Getz, D.M.D.
Caring For Kids Pediatric Dentistry, P.C.

140 Lockwood Avenue, Suite 315, New Rochelle, NY 10801

New Patient Registration

How did you hear of our office? _____

SECTION 1: PATIENT INFORMATION

Patient Name: _____ M / F Date of Birth:_____

Address: _____

City:_____State: _____ Zip Code: _____

SECTION 2: PARENT / GUARDIAN / INSURANCE

Name: _____

Employer: _____

Social Security #:_____ Date of Birth:_____

Address: (if different from patient)_____

City:_____ State: _____Zip Code: _____

Home Phone Number:_____Cell Phone Number:_____

Work Phone Number: _____**E-mail address**_____

Name of Insurance Company: _____

Member's ID:_____Group ID #:_____

Claims and Benefits Phone #:_____

Claims Address:_____City:_____State:_____Zip Code:_____

SECTION 3: DENTAL HISTORY

Former Dentist:_____

Reason for Today's visit:_____

Date of dental last exam:_____Date of last dental x-rays:_____

How often does the patient brush?_____

How often does the patient floss? _____

Does the patient usually fall asleep with a bottle of milk or juice? _____

What does the patient usually drink throughout the day? (juice, water, etc.) _____

Does the patient have any oral habits (thumbsucking, pacifier, etc.)? _____

Has the patient had a previous unfavorable experience at the dentist? (Please describe)

_____

**** Patient Name:** _____

SECTION 4: MEDICAL HISTORY

Physician/Pediatrician Name:_____

Date of Last Visit : _____

Please list any medication(s) the patient is currently taking: _____

_____

Allergies:_____

Please check if the patient has a history of any of the following:

- ☐ ADD
- ☐ ADHD
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hemophilia
- ☐ Heart Murmur
- ☐ Heart Problems

Describe:_____

- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease/Trait
- ☐ Skin Rash
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other (describe below)

Is there any other medical information you think we should know? Please describe: _____

SECTION 5: AUTHORIZATION ** Please read carefully below **

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 or my child's health.

I authorize the dentist to release my information including the diagnosis and the records of any treatment of 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 dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (Or parent if patient is a minor) Date

For Office Use Only – Please do not write below this line

- I verbally reviewed the medical information above with patient's parent/guardian _____ (Doctor's Initials/Date)

  Comments:_____

- I verbally reviewed the medical information above with patient's parent/guardian _____ (Doctor's Initials/Date)

  Comments:_____

- I verbally reviewed the medical information above with patient's parent/guardian _____ (Doctor's Initials/Date)

  Comments:_____

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GENERAL CONSENT FOR TREATMENT

I, _____, am voluntarily seeking dental care and treatment at this facility for my child ,_____. I voluntarily agree to accept routine dental services which may diagnose a dental condition, procedures to treat that condition, and other routine dental care. I understand that these services will be provided to my child by dentists and dental assistants. I have not been given any guarantees as to the results of the services my child will receive.

I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s).

The above consent will remain in effect unless I revoke it.

Print child's name:_____

Signature of Parent or Guardian:_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement (below)

I certify that I am the parent or guardian of the child listed above, and that I have received a copy of this office's Notice of Privacy Practices.

Signature of Parent or Guardian:_____ Date: _____

For Office Use Only – Please do not write below this line

I, _____, am an adult employee of Caring for Kids Pediatric Dentistry, P.C. I hereby declare that the patient or a responsible party has signed this general consent.

Signature of Witness _____ Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

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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 January 1, 2010, 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.

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 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 information 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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 January 1, 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.

Restrictions: 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.

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 restrict 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 Officer: Matthew Getz (office manager)
Tel.: 914-355-2265 E-Mail: caringpediatricdentistry@gmail.com
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