NOW WITH TWO LOCATIONS IN THE CAPITOL REGION

PEDIATRIC DENTAL GROUP of New York

GLENS FALLS
88 Broad Street
Glens Falls, NY 12801

ALBANY
652 Albany Shaker Rd.
Albany, NY 12205

518.798.9966

NEW PATIENT PACKET

www.nypdg.com | YouTube

WELCOME TO THE PEDIATRIC DENTAL GROUP OF NEW YORK

PLEASE TAKE A MOMENT TO TELL US ABOUT YOUR CHILD

Child's Name _____ Nickname _____
(LAST) (FIRST) (MIDDLE INITIAL)

Age _____ Male _____ Female _____ Date of Birth _____ / _____ / _____
(MONTH) (DAY) (YEAR)

Patient's Address _____
(STREET) (CITY) (STATE) (ZIP)

With whom does the patient live? _____ Phone # _____

What is the best way to reach you? ❑ Home ❑ Work _____ ❑ Cell Phone _____
❑ E-mail _____

Please answer the questions by checking either YES or NO. If you are uncertain, leave it unanswered.

1. Is there any specific dental problem you wish to discuss with the doctor? ❑ YES ❑ NO
   If yes, please describe. _____

2. Are you happy with your child's smile? ❑ YES ❑ NO
   If no, what is your concern? _____

3. Which of the following would you like to learn more about? **(Please circle letter)**
   A. Thumb or finger sucking C. Sealants E. Braces G. Other _____
   B. Bad Breath D. Teeth grinding F. Whitening

4. Has your child complained of any dental problems? ❑ YES ❑ NO
   A. If yes, for how long?: _____
   B. If yes, please describe location of pain (i.e. top right, lower left, etc.) _____

5. Has your child ever had an unpleasant dental experience? ❑ YES ❑ NO
   If yes, please describe: _____

6. Has your child ever been under the care of a dentist? ❑ YES ❑ NO
   If yes, name of dentist and date of last visit _____
   Please circle letter of type of care.
   A. Check up/cleaning C. Treatment (fillings, extractions)
   B. Emergency pain relief (toothache) D. Other; describe _____

7. Does your child now take fluoride in any other form other than in toothpaste: _____ ❑ YES ❑ NO
   If yes, circle type: Water Pill Liquid Vitamin

Did you know???

Whistle Toothbrush = Dentist Drill
Bumpy Brush = Dentist Drill
Sleep Drops = Novocain administered with a needle
Wiggles = Extractions
Red Stuff = Blood
Tooth Counter = Explorer
Tickle = To clean the teeth
Tickle Toothbrush = Hygienists tooth brush
Mr. Thirsty = Suction instrument
Vacuum = Suction instrument
Tooth Pillow = Mouth Prop
Counting Teeth = Dr.'s Exam

Please remember, we DO NOT use terms such as Yank, Pull, Rip, Shots or Needles around children.

MEDICAL HISTORY

1. Is your child currently under a physician's care for any reason? ❑ YES ❑ NO
   If yes, please describe: _____

2. Has your child ever been hospitalized? ❑ YES ❑ NO
   If yes, please describe: _____

3. Has your child ever received a blood transfusion? ❑ YES ❑ NO
   If yes, please indicate date(s) and explain: _____

4. Is your child currently taking any medication? ❑ YES ❑ NO
   If yes, please write name, dose and how often taken: _____

   _____

5. Has your child ever had an unusual or allergic reaction to any of the following? **(Please Circle)**

Penicillin/Amoxicillin	Other antibiotics	Local Anesthetics (Novocain)
Aspirin	Codeine	Latex

   If yes, please describe: _____

6. Is your child sensitive or allergic to anything eles? (e.g., food, animals, bees, pollen, dust, etc.) ❑ YES ❑ NO
   If yes, please describe: _____

7. Does your child currently have a heart murmur? ❑ YES ❑ NO
   If yes, doctor's name _____ Phone #: _____

8. Has your child had any of the following? **(Please circle letter)**

A. ADD/ADHD	H. Convulsions (seizures)	O. Heart Disease	V. Rheumatic Fever
B. Anemia	I. Continuous Colds	P. Hepatitis (jaundice)	W. Scarlet Fever
C. Asthma	J. Diabetes	Q. Kidney Disease	X. Speech Problems
D. Autism	K. Down Syndrome	R. Leukemia	Y. Thyroid Conditions
E. Bladder Problems	L. Epilepsy	S. Lung Disease	Z. Tuberculosis
F. Bleeding Problems	M. Fainting Spells	T. Mononucleosis	
G.Cancer	N. Hearing Problems	U. Pneumonia	

Please describe any that are circled (unless already mentioned elsewhere) _____

_____

Please describe any other medical problems not listed here: _____

_____

9. Young women (12 years and older) Is your daughter taking birth control? ❑ YES ❑ NO

10. Is your daughter pregnant? ❑ YES ❑ NO

Whom may we thank for referring you? _____

I hereby certify that the information contained in these forms is accurate and complete to the best of my knowledge.

Signature _____ Date _____

(PARENT OR LEGAL GUARDIAN)

Relationship _____

(THE PEDIATRIC DENTAL GROUP OF NEW YORK)

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}

Additional individuals we can contact or release information to:

_____

_____

For Office Use Only

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

_____

_____

_____

Is there any problem that you would like the doctor to look at or discuss today? ❑ YES ❑ NO

If yes, please describe ____

Medical history changes ____

Is your child currently taking any medications? ❑ YES ❑ NO

If yes, please write the name, dose and how often taken ______________________________

I hereby certify that the information contained in these forms is accurate and complete to the best of my knowledge.

Signature __________________________________ Date ________________

(PARENT OR LEGAL GUARDIAN)

Relationship ____

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If yes, please describe ____

Medical history changes ____

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If yes, please describe ____

Medical history changes ____

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Signature __________________________________ Date ________________

(PARENT OR LEGAL GUARDIAN)

Relationship ____

Is there any problem that you would like the doctor to look at or discuss today? ❑ YES ❑ NO

If yes, please describe ____

Medical history changes ____

Is your child currently taking any medications? ❑ YES ❑ NO

If yes, please write the name, dose and how often taken ______________________________

I hereby certify that the information contained in these forms is accurate and complete to the best of my knowledge.

Signature __________________________________ Date ________________

(PARENT OR LEGAL GUARDIAN)

Relationship ____

GUARDIAN INFORMATION

Date Completed _____

Father's Name _____ Date of Birth _____ Social Security # _____

His address _____ Phone # _____
(STREET) (CITY) (STATE) (ZIP)

Where Employed _____ Phone # _____

Occupation _____

Mother's Name _____ Date of Birth _____ Social Security # _____

Her address _____ Phone # _____
(STREET) (CITY) (STATE) (ZIP)

Where Employed _____ Phone # _____

Occupation _____

What is the best way to reach you? ❑ Home ❑ Work _____ ❑ Cell phone _____

❑ Email _____

DENTAL INSURANCE

Dental Insurance? ❑ YES ❑ NO If yes, more than one plan? _____

Name of Insurance Company _____

ID # _____ Group # _____

Name of policy holder _____

If dual coverage..Name of Secondary Insurance Company _____

ID # _____ Group # _____

Name of secondary policy holder _____

MEDICAL / DENTAL PROVIDERS

Child's Physician _____ Phone # _____

Physician's Address _____

Child's Former Dentist _____ Phone # _____

Dentist's Address _____ Date of last visit _____

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For patient privacy reasons, as well as providing the best care possible for your child, we cannot see any child unless the parent or legal guardian accompanies them. If there is a chance you may need someone other than yourself to bring your child to any future appointments, please list the name of that person below. You may list more than one person to give permission to accompany to appointments if needed. Please note that a parent or legal guardian must be present for all treatment appointments. By listing the names below you are giving permission to that person to bring your child if needed. This will be kept in your child's chart for us to refer back to if ever needed. Thank you!

_____

_____

_____

_____

Our office will also need a phone number where you (the parent) or legal guardian can be easily contacted in the case that someone else listed does accompany your child to an appointment and we need to reach you. Thank you!

_____ _____

Child or Children's Name: Date:

_____

Parent's Name: (Please Print)

_____

Parent's Signature:

_____

Daytime Phone Number:

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Every effort tis made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. Our standard office policy regarding appointments is as follows:

We try to remind patients by telephone prior to the appointment, but **please do not depend on this courtesy.** If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to be present. That appointment date and time has been reserved especially for you. We reserve the right to charge for office visits cancelled or broken without 24 hours advanced notice. Operative and sedation appointments must be cancelled within 48 hours notice to avoid a charge. Your child's dental health is extremely important for their overall health and we take these appointments seriously. Exceptions to this policy can be determined on an individual basis according to the circumstances.

Appointments that are "broken" without any advance notice are considered a "no show". On the second occurrence, your file will be reviewed for consideration of being discharged from our practice.

The broken appointment charge will depend on the procedure and time reserved with a minimum charge of $25.

If you have any questions about this policy, do not hesitate to ask any member of our staff. They will be glad to answer your questions. We believe that good communication is the key to excellence in the care provided for your child.

Thank you for your cooperation.

Patient Name: _____

Parent Signature: _____

Relationship to Patient: _____

Date: _____

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OFFICE FINANCIAL POLICY

In order to make payment for services as convenient as possible for you, we offer 4 payment options. We will attempt to give you an accurate estimate of your total fees at the onset of your treatment and will update them as needed.

Plan A: Total payment for the fee at each visit. We accept cash, check, Mastercard, VISA or Discover.

Plan B: Long-term financing is available to patients who qualify through Citi Health Card, Dental Fee Plan or Care Credit. Applications and details may be obtained from our office staff.

Plan C: Automatic withdrawals from your checking or savings account up to three months offered on the 5th, 15th and 25th of the month.

Plan D: Insurance. A completed and signed insurance form must be provided at the patient's first appointment. Whenever, necessary, a pre-treatment estimate form will be submitted to your insurance carrier prior to treatment to obtain an estimate of your insurance benefits. The amount not covered by your insurance is payable at the time of service.

I understand that if my insurance denies payment for any reason, I am financially responsible for the entire balance.

Please fee free to call for clarification of our stated options.

_____ _____

Parent/Legal Guardian's Signature Date

THE PEDIATRIC DENTAL GROUP OF NEW YORK

Albany, NY | Glens Falls, NY

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.

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.

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: Karen Sani

Telephone: 518-798-9966 Fax 518-798-0616

E-mail: karen@nypdg.com

Address: 88 Broad Street , Glens Falls NY 12801

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14,2002).