Mrunal Parmar, DDS
www.thesmilestop.com
info@thesmilestop.com
Tel: (201) 391-8516

Patient Information

Today's Date: _____

Child's Name: _____

Birthdate: _____ /_____ /_____ Male Female

Preferred Name: _____

Home Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last Dental Visit: ____ /____ /____ Where?: _____

Accompanying Guardian

Name: _____

Relationship to Patient: _____

How did you hear about us?

☐ Referred by Doctor (Who? _____)

☐ Referred by Family/Friend (Who? _____)

☐ Insurance

☐ Other: _____

Parent(s) Information

Mother's Name: _____

Birthdate: ____ /____ /____ Home #: _____

Work #: _____ Cell #: _____

SSN: _____

Occupation: _____

Email: _____

Father's Name: _____

Birthdate: ____ /____ /____ Home #: _____

Work #: _____ Cell #: _____

SSN: _____

Occupation: _____

Email: _____

Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered

Primary Dental Insurance

Policy Owner's Name: _____

Policy Owner's Birthdate: ____ /____ /____

Insurance Company Name: _____

Policy Owner ID#: _____

Child's Relationship to Policy Owner: _____

Policy Owner's Employer: _____

Insurance Company Address: _____

_____

Insurance Company Phone #: _____

Secondary Dental Insurance

Policy Owner's Name: _____

Policy Owner's Birthdate: ____ /____ /____

Insurance Company Name: _____

Policy Owner ID#:_____

Child's Relationship to Policy Owner: _____

Policy Owner's Employer: _____

Insurance Company Address: _____

_____

Insurance Company Phone #: _____

I certify that my child is covered by the above insurance company and I assign directly to The Smile Stop Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying co-payments and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

Signature of Parent/Guardian: _____ Date: _____

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Medical / Dental History

Patient's Name _____ Birthdate _____ / _____ / _____

Has your child ever had a serious/difficult problem associated with previous dental work? Yes ☐ No ☐

If Yes, please explain: _____

Is the child's water fluoridated? Yes ☐ No ☐ Is the child taking fluoride supplements? Yes ☐ No ☐

What is the reason for today's dental visit?: _____

Does the child brush his/her teeth daily? Yes ☐ No ☐

Has your child ever injured their mouth, teeth, or head? If yes, please explain: Yes ☐ No ☐

Child's Physician: _____ Phone Number: _____

Date of last visit: _____

Please describe the child's current physical health: Good ☐ Fair ☐ Poor ☐

Is the child up to date on all immunizations? If no, please explain. Yes ☐ No ☐ _____

Please list all medications the child is currently taking: _____

Aside from the items listed below, please list anything the child is allergic to, including medication: _____

Latex: Yes ☐ No ☐ Metals/Nickel: Yes ☐ No ☐ Plastic: Yes ☐ No ☐

Has the child ever had any of the following medical issues?

Abnormal Bleeding	Yes ☐	No ☐	Congenital Heart Defect	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐
ADD/ADHD	Yes ☐	No ☐	Convulsions	Yes ☐	No ☐	Kidney/Liver Problems	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Measles	Yes ☐	No ☐
Any Hospital Stays	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐	Mononucleosis	Yes ☐	No ☐
Any Operations	Yes ☐	No ☐	Exposed to HIV, but Neg	Yes ☐	No ☐	Sensory Issues	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Headaches	Yes ☐	No ☐	Skin Rash	Yes ☐	No ☐
Autism/Asperger's	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐	Tuberculosis (TB)	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Other	_____	

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform The Smile Stop of any changes in my child's medical status or dental health. I authorize the dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature _____ Date _____

Delegation of Power by Parent or Guardian

Only if applicable

I give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke this consent at any time by providing written notice.

Persons who have my consent in my absence are:

1. _____
2. _____

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Parent/Guardian Signature _____ Date _____

Office Policies

Patient's Name _____ Birthdate _____ / _____ / _____

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our practice policies is important to our relationship.

Appointments

We ask for your utmost courtesy regarding your scheduled appointments as we exclusively reserve time to care for your child. Please allow 48 hours prior to the appointment time if you must cancel or reschedule. We understand that unforeseen business and personal emergencies do occur; however, repeated last minute cancellations and broken appointments will incur a charge of $25. Most insurance companies will not reimburse the cost of a missed appointment.

Fees and Payment Policies

In an effort to make needed services more affordable, payment for professional services is due at the time dental treatment is provided. If you have insurance, than your co-payment is due as service is rendered. If an account shows an overdue balance, future treatment may be delayed until the balance is cleared. The accompanying adult and/or parent is responsible for payment at the time of the appointment. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express.

About Insurance

In-Network Insurance Patients*:* We are a preferred provider for many major insurance dental plans. If we are an in-network provider for your policy, we will file your claim as a courtesy and will accept estimates of benefit payments from these insurance companies. Your portion of co-payment and/or co-insurance is due at the time of service. Please keep in mind that **this is only an estimate of what your insurance will cover for you**. If there is any difference after your insurance pays, we will contact you to make the necessary adjustments.

Out-of Network Insurance Patients*:* If we are out-of-network for your insurance, please check for any out-of-network benefits and we will file our claims for you as a courtesy. Although we can estimate what your insurance company will pay, there is no guarantee of reimbursement. Therefore, we require payment in full on the day of service.

Patients without Dental Insurance*:* For those without dental insurance, payment is required the same day services are rendered, regardless of who accompanies that child to his or her appointment.

It is important to understand that your insurance is a contract between you, your employer, and the insurance company, not our office. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of fees for treatment. We cannot guarantee what your insurance will or will not do with each claim. We cannot be responsible for accuracy of any insurance information. Your insurance company representative has provided this information to us. It is your responsibility to be familiar and understand your insurance policy and terms. **You are responsible for payment not paid by your insurance company.**

I have read the above conditions and agree to their content.

Signature of Parent/Guardian: _____ Date: _____

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Privacy Policy

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us. You may request a copy of our current Notice of Privacy Practices at any time.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or statime.

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 our contact information. 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

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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.

Patient's Name _____ Birthdate _____ / _____ / _____

I understand that my child has rights to privacy regarding his or her protected health information. These rights are provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which went into effect on April 14, 2003. I understand that by signing this consent I authorize The Smile Stop, Dr. Parmar and their staff to use and disclose my child's protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in this treatment);
- Obtaining payment from third party payers (e.g. your insurance company);
- The day-to-day healthcare operations of the practice.

I have been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my child's protected health information, and my child's rights under HIPAA. I understand that The Smile Stop and Dr. Parmar reserve the right to change the terms of this notice from time to time and that I may contact this office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions of how my child's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that The Smile Stop and Dr. Parmar are not required to agree to these requests. However, if the restrictions are agreed to then they must be complied with.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I have read the above conditions and agree to their content.

Patient Name: _____

Signature of Parent/Guardian: _____ Date: _____

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Photography Release / Consent Form

We are committed to making every effort possible to make our patients feel special. We like to put our patients on "display" by using pictures from any drawings / prize winnings / fun events and posting them in our office, on our Facebook page, website and Instagram. Pictures may be used for dental education including lectures, presentations and professional publications. Please check one of the following boxes and sign below.

☐ **I agree** and hereby grant full permission to The Smile Stop Pediatric Dentistry, Dr. Mrunal Parmar and staff, to use either myself or my child / children's name(s) and photograph in any publication or advertising materials (printed or electronic). This consent also serves to waives all rights of privacy or compensation in connection with the use of my photograph and/or my child's photograph and/or name.

Be sure to follow our social media sites to see your child's smile!
www.thesmilestop.com
www.instagram.com *@thesmilestoppd*
www.facebook.com *@thesmilestop*

☐ **I do not agree** to have mine or my child's information or photograph used for public viewing.

Patient's Name: _____

Name of Parent / Guardian: _____ Relationship to Child: _____

Signature of Parent/Guardian: _____ Date: _____